No. _____ (1)

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1998

WASHINGTON PHYSICIANS SERVICE ASSOCIATION; PACIFICARE OF WASHINGTON, INC., a health care service contractor; SELECTCARE HEALTH PLANS, a Health Maintenance Organization; QUALMED WASHINGTON HEALTH PLAN, INC., a Health Maintenance Organization; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, INC., a Health Maintenance Organization; BLUECROSS AND BLUESHIELD OF OREGON, a health care service contractor; GROUP HEALTH COOPERATIVE OF PUGET SOUND, a Health Maintenance Organization; PREMERA BLUE CROSS (formerly BLUE CROSS OF WASHINGTON AND ALASKA, and MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON), a health care service contractor; REGENCE BLUESHIELD (formerly PIERCE COUNTY MEDICAL BUREAU, INC., and KING COUNTY MEDICAL BLUESHIELD), a health care service contractor,

Petitioners,

v.

CHRISTINE GREGOIRE, in her official capacity as Attorney General for the State of Washington; DEBORAH SENN, in her official capacity as Insurance Commissioner of the State of Washington,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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ISSUE PRESENTED FOR REVIEW

Whether the United States Court of Appeals for the Ninth Circuit erred in holding, contrary to the opinions of this Court and other Federal Circuits, that RCW 48.43.045(1), the Washington State "Alternative Provider" or "Every Category of Provider" law, is not preempted by ERISA because the Statute (i) does not "relate to" an employee benefit plan and (ii) it is state law saved by the savings clause (29 U.S.C. § 1144(b)(2)(A)), as a law that regulates insurance.

PARTIES

The Petitioners are:

WASHINGTON PHYSICIANS SERVICE ASSOCIATION; PACIFICARE OF WASHINGTON, a health care service contractor; SELECTCARE HEALTH PLANS, a Health Maintenance Organization; QUALMED WASHINGTON HEALTH PLAN, INC., a Health Maintenance Organization; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, INC., a Health Maintenance Organization; BLUECROSS AND BLUESHIELD OF OREGON, a health care service contractor; GROUP HEALTH COOPERATIVE OF PUGET SOUND, a Health Maintenance Organization; PREMERA BLUE CROSS (formerly BLUE CROSS OF WASHINGTON AND ALASKA, and MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON), a health care service contractor; REGENCE BLUESHIELD (formerly PIERCE COUNTY MEDICAL BUREAU, INC., and KING COUNTY MEDICAL BLUESHIELD), a health care service contractor.

Pursuant to Rule 29.6 of the Rules of the Supreme Court, Petitioners state as follows: (i) the parent companies for Washington Physicians Service Association are Regence BlueShield, Kitsap Physicians Service, and Northwest Washington Medical Bureau; Washington Physicians Service Association has no non-wholly owned subsidiaries; (ii) the parent companies for PacifiCare of Washington, Inc. are PacifiCare Benefits Administrators, Inc., PacifiCare Operations, Inc., and PacifiCare Health Systems, Inc.; PacifiCare of Washington, Inc. has no non-wholly owned subsidiaries; (iii) SelectCare Health Plans has no parent company or non-wholly owned subsidiary;

PARTIES – Continued

(iv) the parent companies for QualMed Washington Health Plan, Inc. are QualMed, Inc. and Foundation Health Systems, Inc.; QualMed Washington Health Plan, Inc. has no non-wholly owned subsidiaries; (v) the parent corporation of Kaiser Foundation Health Plan of the Northwest, Inc. is Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of the Northwest, Inc. has no non-wholly owned subsidiaries; (vi) the parent corporation of BlueCross and BlueShield of Oregon is The Regence Group; BlueCross and BlueShield of Oregon has no non-wholly owned subsidiaries; (vii) the parent corporation of Regence BlueShield is The Regence Group; Healthcare Management Administrators, Inc. is a non-wholly owned subsidiary of Regence BlueShield; (viii) Group Health Cooperative of Puget Sound has no parent companies; Alliance Operating Services is a non-wholly owned subsidiary of Group Health Cooperative of Puget Sound; (ix) the parent corporation of Premera Blue Cross is PREMERA; Premera Blue Cross has no non-wholly owned subsidiaries.

The Respondents are:

CHRISTINE GREGOIRE, in her official capacity as Attorney General for the State of Washington; DEBORAH SENN, in her official capacity as Insurance Commissioner of the State of Washington.

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PETITION FOR WRIT OF CERTIORARI

Petitioners, Washington Physicians Service Association, et al., respectfully submit that a writ of certiorari should be issued to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The Opinion of the Ninth Circuit Court of Appeals, as amended on denial of rehearing and suggestion for rehearing *En Banc*, entered on August 24, 1998, is reported at 147 F.3d 1039 (9th Cir. 1998), App. 1 to 22. The original opinion is reprinted in the Appendix ("App.") at App. 23 to App. 40. The District Court's Opinion granting summary judgment to Petitioners and denying reconsideration is reported at 967 F. Supp. 424 (W.D. Wa. 1997), App. 43 to 58. The District Court's Opinion denying reconsideration and holding that RCW 48.43.045(2) is severable is reprinted at App. 41-42. In addition, the Insurance Commissioner issued a Declaratory Order interpreting RCW 48.43.045, App. 59 to 93.

JURISDICTION

The Court of Appeals' Order denying Washington Physicians Service Associations' Petition for Rehearing, with a suggestion for rehearing *En Banc*, was entered on August 24, 1998. This Court has jurisdiction pursuant to 28 U.S.C. §1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves the statutes and regulations set forth in App. 94 to App. 160. In particular, it involves RCW 48.43.045(1) which is reprinted at App. 111 to 112.

STATEMENT OF THE CASE

A. Background

RCW 48.43.045(1), App. at 111-112, known as the Alternative Provider Statute or Every Category of Provider Statute, required that every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, permit every category of health care provider to provide health services or care for conditions included in the basic health plan services, to the extent that: (a) such health services or care is within the health care providers' permitted scope of practice and (b) the providers agree to abide by standards related to: (i) provision, utilization review, cost containment; (ii) management and administrative procedures; and (iii) provision of cost-effective and clinically efficacious health services.

Petitioners are health carriers under RCW 48.43.005(17), App. at 107, who are doing business in the State of Washington. Petitioners delivered, issued or renewed health plans after January 1, 1996. A Petition for Declaratory Order was filed with the Office of Insurance Commissioner ("OIC") on May 21, 1996. The Petitioners requested that the OIC interpret RCW 48.43.045. On August 21, 1996, the OIC issued a Declaratory Order, App. at 59-93, hereinafter "State Interpretation."

On September 19, 1996, Petitioners filed a Complaint for Declaratory and Injunctive Relief against the Attorney General for the State of Washington and against the Insurance Commissioner of the State of Washington. Jurisdiction was based on a federal question, preemption of a state statute by ERISA. On May 2, 1997, the United States District Court for the Western District of Washington, granted summary judgment in favor of Petitioners, holding that the Statute and State's Interpretations are preempted by ERISA. App. at 58. On July 23, 1997, the District Court denied the Respondents' Motion for Reconsideration, but held although RCW 48.43.045(1) is preempted, RCW 48.43.045(2) is severable and may be enforced. App. at 42.

B. The Ninth Circuit's Decision

On June 18, 1998, a three-judge panel for the Ninth Circuit reversed the District Court. The Ninth Circuit held that RCW 48.43.045(1) did not "relate to" an employee benefit plan and even if the relation to test was met, the Statute was saved from preemption, as a state law regulating insurance. App. at 12.

On August 24, 1998, the three-judge panel denied the Petition for Rehearing, and the Suggestion for Rehearing *En Banc* was rejected. App. at 5. In holding that RCW 48.43.045 was not preempted by ERISA, the Ninth Circuit rejected Petitioners' argument that the Statute "references" ERISA plans because it applies only to health plans and refers to employer self-funded plans. App. at 9, 12. The Ninth Circuit also rejected Petitioner's arguments that the Statute has a "connection to" employee benefit

laws because it affects the structure of health plans, imposes an administrative burden on health plans, and controls administrative choices about whom to contract with and whom to pay. App. at 12. The Ninth Circuit found that the Statute was one of general applicability – merely regulating a product that the employee benefit plan might choose to buy and, therefore, does not "relate to" an ERISA plan. App. at 12-13.

After finding that the Alternative Provider Statute was akin to a statute of general applicability, the Ninth Circuit adopted an inconsistent analysis that the Statute is not generally applicable, but instead is solely a state law regulating insurance and is, therefore, saved from preemption. App. at 14. The Ninth Circuit's reasoning is inconsistent with the holdings of this Court and the Fifth and the Eighth Circuits and, its interpretation of the McCarran-Ferguson Test is inconsistent with the Third, Fifth, Seventh, Eighth, Tenth and Eleventh Circuits. Supreme Court review is necessary to resolve these conflicts.

REASON FOR GRANTING THE WRIT

1. The Ninth Circuit's construction of the "relates to" test for ERISA preemption renders the "savings clause" obsolete and effectively overrules this Court's decision of *Metropolitan Life Insurance Company v. Massachusetts.*

The Alternative Provider Law applies to every health plan issued by a Health Carrier. Under Sections 3(1), 29 U.S.C. §1002(1) and 3(3), 29 U.S.C. §1002(3) of the

Employee Retirement Income Security Act of 1974, as amended ("ERISA"), all health plans are employee benefit plans. App. at 130. ERISA supersedes "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." ERISA §514(a), 29 U.S.C. §1144(a), App. at 139. A law "relates to" an employee benefit plan if it has a "connection with" or a "reference to" such a plan. *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 2898-99 (1983).

The Ninth Circuit held that the Statute does not "relate to" an employee benefit plan because the terms refer to a plan offered by a health carrier and not a benefit plan offered by the employer. App. at 9. By so holding, the Ninth Circuit suggests that insured plans are *not* subject to ERISA, e.g., such plans are not offered by the employer, while self-insured plans "offered by the employer" are subject to ERISA. Such an analysis is contrary to the statutory scheme of ERISA which makes no distinction between insured and self-insured plans:

> [t]he term "employee welfare benefit plan" . . . means any plan, fund or program . . . maintained for the purpose of providing for its participants or their beneficiaries, through the *purchase of insurance or otherwise* (a) medical, surgical, or hospital care or benefits. . . .

App. at 130 (emphasis added).

The Ninth Circuit's analysis, is also in direct conflict with this Court's holding in *Metropolitan Life*:

> Plans that purchase insurance – so called "insured plans" – are directly affected by state laws that regulate the insurance industry.

Metropolitan Life v. Massachusetts, 471 U.S. 724, 731, 105 S.Ct. 2380, 2385 (1985). The Ninth Circuit attempted to distinguish *Metropolitan Life* by suggesting that the Washington law governs the benefit plan offered by the insurance carrier and not the benefit plan offered by the employer. App. at 9. Contrary to the Ninth Circuit's suggestions, App. at 11, *Metropolitan Life* also governed the product offered by the insurance carrier and not the benefit plan offered by the employer. *Metropolitan Life* was concerned with Section 47B of the Massachusetts Code which required insurance policies to provide coverage for mental or nervous conditions. This Court held that a state law that governs the type of benefits that an "insured plan" may purchase relates to an ERISA plan and is preempted, unless saved by the "savings clause:"

> Though §47B is not denominated a benefit-plan law, it bears indirectly but substantially on all insured benefit plans, for it requires them to purchase the mental-health benefits specified in the Statute when they purchase a certain kind of common insurance policy.

Id. 471 U.S. 724, 738; 105 S.Ct. 2380, 2388. Under *Metropolitan Life*, RCW 48.43.045 clearly relates to ERISA plans as it similarly regulates both the type of "insurance" and the type of "arrangements" that may be entered into by health plans, e.g., such arrangements and insurance must provide for "every category of provider." Moreover, because all "insurance" laws are aimed at the product sold by the insurer, the Ninth Circuit's analysis would render the "savings clause" obsolete. The Ninth Circuit's analysis creates an arbitrary distinction between insured and self-insured plans that is inconsistent with prior

holdings of this Court and review by this Court is, therefore, appropriate.[1]

2. The Ninth Circuit's analysis that the Alternative Provider Statute is more akin to a statute of general applicability than a "mandated benefit" statute is in direct conflict with this Court's decision in *New York State Conference of Blue Cross and Blue Shield v. Travelers* and *DeBuono v. NYSA-ILA Medical & Clinical Services Fund* and the Fourth, Fifth, Eighth and Tenth Circuits.

The Ninth Circuit ignored the essential holdings of this Court when it likened, RCW 48.43.045 to a hospital surcharge, *Travelers*, or a gross receipts tax, *DeBuono*. The Ninth Circuit stated:

> In the end, what saves the Act from ERISA preemption is that it does not have anything to do with employee benefit plans in particular. It is merely one of the many state laws that

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[1] The Ninth Circuit's distinction between plans "offered by the insurance carrier" and "benefits offered by the employer," App. at 9, is also contrary to existing Department of Labor regulations and case law. Existing Department of Labor regulations, and case authority, firmly establish that ERISA extends to plans "offered by insurers" and not merely "benefits offered by employers," if the employer has any involvement with the plan. *See Silvera v. Mutual Life Insurance Co. of New York*, 884 F.2d 423, 425 (9th Cir. 1989); *Crull v. GEM Insurance Company*, 58 F.3d 1386, 1389-90 (9th Cir. 1995); *Pacificare, Inc. v. Martin*, 34 F.3d 834, 837 (9th Cir. 1994); 29 C.F.R. §2510.3-1(j), App. at 159-160 (a welfare plan shall include an "insurance program offered by an insurer" to employees).

> regulates one of many products that an employee benefit plan might choose to buy. . . .

App. at 12.

This analysis that the purchase of insurance is merely a product that does not "relate to" employee benefit plans was specifically rejected by this Court in *Travelers*:

> . . . laws like the one in *Metropolitan Life* relate to plans since they bea[r] indirectly but substantially on all insured plans, . . . requir[ing] them to purchase the mental-health benefits specified in the statute when they purchase a certain kind of *common insurance policy*. . . .

Travelers, 514 U.S. at 663, 115 S.Ct. at 1682 (emphasis added).

Contrary to the Ninth Circuit's holding, the *Travelers* court reaffirmed its position that preemption will apply to any state law that attempts to regulate: (i) the structure; (ii) the content; (iii) the method of administration; or (iv) plan requirements that may vary from state to state. *New York State Conference of Blue Cross and Blue Shield v. Travelers Insurance Co.*, 514 U.S. 645, 656-58, 115 S.Ct. 1671, 1677-78; *Accord DuBuono v. NYSA-ILA Medical and Clinical Service Fund*, 520 U.S. 806, 117 S.Ct. 1747, 1752 (1997) (gross receipts tax did not target the structure, the content or the administration of ERISA plans).

RCW 48.43.045(1) "relates to" employee benefit plans because it interferes with administration and structure of health plans. The Alternative Provider Statute and State Interpretations clearly prohibit ERISA plans from selecting an arrangement that does not cover every category of provider or which provides different reimbursement

levels for different providers. App. at 83. In examining a similar state statute dealing with "any willing provider," the Fifth Circuit found such arrangements were related to the structure of the plan within the meaning of this Court's *Traveler's* decision and were preempted. *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana*, 82 F.3d 642, 649 (5th Cir. 1996).

The Washington State Insurance Commissioner ("Commissioner") has stated, App. at 82, that a Health Plan cannot exclude treatment of the common cold by acupuncture, unless a Health Plan can show that other treatments for the common cold are more cost-effective and clinically efficacious. As this example indicates, a very significant administrative burden is imposed on Health Plans to ensure that any standards placed on providers do not operate to discriminate or exclude. Either the plan administrator must yield to the State's mandate to include every provider for every condition, or laboriously attempt to prove the negative, that is, that treatment by a particular category of provider is neither clinically efficacious nor cost effective.

The Insurance Commissioner has further decreed that a Health Plan "may not discriminate" among categories of providers, as the same "requirements" must be imposed on all providers in the same category. App. at 80. In the absence of such a mandate, a health plan may opt to exclude a category of providers or even set different requirements for reimbursement among providers. Indeed, a plan administrator often can achieve better service and lower cost by negotiating with providers or

particular groups of providers on a selective basis. Similarly, a plan administrator can achieve better price discounts as a result of competition among providers for the same plan business. The Alternative Provider Statute removes flexibility from the plan administrator by precluding such a viable structure. Therefore, the Alternative Provider Statute "relates to" the Health Plans.[2]

RCW 48.43.045(1) also interferes with the uniform administration of health plans. The intent of Congress in passing ERISA was to "eliminate the threat of conflicting and inconsistent state and local regulation." *See Travelers*, 514 U.S. 645, 657-658, 115 S.Ct. 1671, 1678 (1995). This Court has applied the preemption clause to avoid even the mere potential for multiple laws that would produce inefficiencies in the nationwide administration of employee benefit plans. *See Ingersoll-Rand Company v. McClendon*, 498 U.S. 133, 142, 111 S.Ct. 478, 484 (1990); *FMC Corp. v. Holliday*, 498 U.S. 52, 57-58, 111 S.Ct. 403, 407 (1990). In the instant case, the term Health Plan includes "arrangements" to reimburse or to provide or arrange for health care services. Therefore, an employer in Oregon who contracts with a Health Carrier in

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[2] Moreover, while the Alternative Provider Statute does contain a limited exception for "employer-sponsored" self-funded and self-administered plans, it contains no exception for self-insured plans maintained by unions, employees or other organizations or groups. *See* RCW 48.43.005(18)(i), App. at 108. These union and organization plans would have to change their structure to comply with the Alternative Provider Statute and State Interpretations, regardless of whether such plans are self-administered. Such a change in administration "relates to" ERISA in a manner that violates the Deemer Clause.

Washington to cover employees in Washington would be forced to comply with the state statutory mandate of "every category of provider."

Similarly, the possibility exists for disparate treatments between participants of any plan which utilizes a federally qualified HMO for the coverage of some of its employees and a non-federally qualified HMO or a health care service contractor for other employees. This results from the fact that the federal HMO Act itself preempts state requirements which are inconsistent with HMO Act requirements and prevents the HMO from carrying on business in the state. 42 U.S.C. §300e-10(a), (c) and (e), App. at 148. The Commissioner, in her Declaratory Order, purports to regulate an HMO's ability to apply a "clinically efficacious" standard to its providers, and purports to prohibit the standard entirely if the result is to exclude an entire category of providers. *Id.* Such a rule is inconsistent with the federal HMO Act and would be preempted as applied to federally qualified HMOs. *Accord, Prudential Insurance Company of America v. National Park Medical Center, Inc.*, 154 F.3d 812, 821 (8th Cir. 1998). Thus, plans offering coverage both from federally qualified HMOs and from other health carriers could be faced with different benefit structures.

In summary, as established by *Travelers*, state laws that force an ERISA plan to adopt a certain scheme of coverage or interfere with the administration of the plan are preempted. *Travelers*, 514 U.S. at 668, 115 S.Ct. at 1683. RCW 48.43.045 clearly forces plans to adopt a scheme of coverage, e.g., coverage for alternative providers, which affects the content and administration of employee benefit plans. The Ninth Circuit's Opinion is in direct conflict

with this Court's decisions in *Travelers* and *Metropolitan Life*. The Ninth Circuit's "relation to" analysis is also in conflict to the decisions of the Fourth, Fifth, Eighth and Tenth Circuits.[3] Supreme Court review is necessary to ensure uniform enforcement of the holdings of this Court and uniform administration of health plans.

3. There is no practical distinction between Washington's Alternative Provider Law and an Any Willing Provider Law. A conflict exists between the: (i) Ninth, Tenth and Fourth Circuits; and (ii) Fifth and Eighth Circuits regarding the Savings Clause and ERISA preemption. Resolving such conflict involves an interpretation of this Court's Opinion in *Royal Drug*.

A mandated provider or alternative provider law affirmatively mandates that health carriers pay specified providers at the same reimbursement as preferred providers. An any willing provider law requires that preferred status be granted to any provider willing to meet specified terms and conditions. The end result of both laws is the same – the health carrier must pay certain providers who were previously non-preferred providers at the same rate as preferred providers. Under either

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[3] *See Stuart Circle Hospital Corp. v. Aetna*, 995 F.2d 500, 502 (4th Cir. 1993); (Virginia preferred provider statute "relates to" ERISA); *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana*, 82 F.3d 642, 648 (5th Cir. 1996) (Louisiana "any willing" provider law "relates to" ERISA); *Prudential Insurance Company of America v. National Park Medical Center, Inc.*, 154 F.3d 812, 821 (8th Cir. 1998) (Arkansas Patient Protection Act "relates to" ERISA); *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331, 1332 (10th Cir. 1986) (Kansas mandated provider was assumed to have met the "relates to" test).

statute, the insured who wishes to be treated by health practitioner "X," may or may not be able to receive reimbursement for such treatment, because "X" may not be one of the specified providers recognized by the health carrier, in the case of mandated or alternative provider statute, or "X" may not have agreed to the terms and conditions of the provider contract, in the case of an any willing provider law. Thus, there is no practical distinction between a mandated provider law and an any willing provider law.

To date, five Circuits have decided cases relating to mandated provider or alternative provider laws. *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996); *Texas Pharmacy Association v. Prudential Insurance Company of America*, 105 F.3d 1035 (5th Cir. 1997); *Prudential Insurance Company of America v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998); *Blue Cross and Blue Shield of Kansas City v. Bell*, 798 F.2d 1331 (10th Cir. 1986); *Stuart Circle Hospital Corporation v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993); *Washington Physicians Service Association v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998). With the exception of the Ninth Circuit, all of the Circuits have found the "reference to" prong of preemption satisfied. *CIGNA*, 82 F.3d at 648; *Texas Pharmacy*, 105 F.3d at 1037; *National Park*, 154 F.3d at 925; *Stuart Circle*, 995 F.2d at 502; *Bell*, 798 F.2d at 1332. A more even split has developed as to whether such laws are "saved" from preemption as a law regulating insurance. The Fifth and the Eighth Circuits have found that such laws do not regulate the insurance industry in the "common sense" view because the statute extends beyond the insurance industry to entities that merely "arrange" or

"reimburse" for health care services. *National Park*, 154 F.3d at 829; *Texas Pharmacy*, 105 F.3d at 1038; *CIGNA*, 82 F.3d at 649. On the other hand, the Ninth, Tenth and Fourth Circuits have found such laws are saved from preemption as a law regulating insurance and that such laws do not extend beyond the insurance industry because such laws are directed at entities in the health service field. *Stuart Circle*, 995 F.2d at 503; *Washington Physicians Service Assoc.*, 147 F.3d at 1045-1046; *Bell*, 798 F.2d at 1334. Central to resolving this split in the Circuits is an interpretation of this Court's Opinion in *Royal Drug*, (*Group Life and Health Ins. Co. v. Royal Drug*, 440 U.S. 205, 99 S.Ct. 1067, 59 L.Ed. 261 (1979)), concerning the nature of relationship between the insurer and insured and the nature of the business of insurance. There is a striking similarity between the pharmacy agreements in *Royal Drug* and a health plan's limited provider agreement that restrict participation to particular providers and categories of providers. The insureds in *Royal Drug* received a certain level of reimbursement for medical treatment if they used pharmacists from a preferred list and had to pay more for their medication if they used pharmacists who were not part of the network agreement. *Id.*, 440 U.S. at 209, 99 S.Ct. at 1072. Similarly, individuals covered by a health plan receive a certain level of reimbursement or benefits if they choose among physicians (which may be only specified categories of providers) included in a network, and generally receive less or no reimbursement if such individuals choose other providers. Also, just as the pharmacy agreements were a means to control Blue Shield's cost in *Royal Drug*, so are limited provider arrangements used to limit a health plan's costs for health

care treatment. Under this analysis, RCW 48.43.045(1) is preempted because the Statute merely regulates the purchase of goods and services and does not regulate the business of insurance. *Accord, National Park*, 154 F.3d at 827-828 (8th Cir. 1998). On the other hand, *Royal Drug* has been distinguished by other Circuits, finding that the choice of provider is not merely a "good or service" but, rather, an element of the insurance risk which an insured must bear. *Stuart Circle*, 995 F.2d at 504 (4th Cir. 1993). Review by this Court is necessary to resolve this conflicting interpretation of *Royal Drug* and to resolve the split in the Circuits as to the proper interpretation of the Savings Clause.

4. The Ninth Circuit's holding with respect to the McCarran-Ferguson criteria directly conflicts with the Third, Fifth, Seventh, Eighth, Tenth and Eleventh Circuits. Its holding with respect to risk shifting and laws directed at the insurance industry conflicts with the Fifth and Eighth Circuits. Review is necessary to resolve these conflicts.

Because the Statute and the Interpretations "relate to" ERISA plans, they are preempted unless they fall within the narrow scope of ERISA's so-called "Savings Clause." ERISA's Savings Clause, 29 U.S.C. §1144(b)(2)(A), ERISA §514(b)(2)(A), App. at 139, exempts from ERISA's broad preemptive effect state laws which regulate insurance, banking or securities. This exception for insurance regulation is itself limited, however, by the provision that an employee welfare benefit plan may not "be deemed to be an insurance company or other insurer," ERISA's so-called "Deemer Clause." *See* ERISA

§514(b)(2)(B), 29 U.S.C. §1144(b)(2)(B); *Pilot Life v. Dedeaux*, 481 U.S. 41, 45, 107 S.Ct. 1549, 1552 (1987). The phrase "which regulates insurance" as used in the Savings Clause was initially defined by the U.S. Supreme Court in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724, 740-44, 105 S.Ct. 2380, 2389-92 (1985) in which the Court adopted a two-step analysis, including a "common sense" view, analyzing whether the law at issue is specifically directed at the insurance industry, and thus, logically within the scope of the "regulates insurance" language of the Savings Clause, and secondly, whether the law regulates the "business of insurance" as described by the McCarran-Ferguson Act. A conflict exists between the Circuits as to whether all three parts of the McCarran-Ferguson test must be satisfied. The Third, Fifth, Seventh, Eighth, Tenth and Eleventh Circuits hold that a state law must be treated as regulating insurance under both the "common sense view" and all three parts of the McCarran-Ferguson analysis in order to be saved from preemption.[4] In direct

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[4] *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996); *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993); *Insurance Bd. v. Muir*, 819 F.2d 408, 412 (3rd Cir. 1987) (state law that fails to transfer risk preempted); *McMahan v. New England Mut. Life. Ins. Co.*, 888 F.2d 426, 428-430 (6th Cir. 1989) (state law that fails to transfer risk or satisfy third factor is preempted); *DeBruyne v. Equitable Life Assur., Soc.*, 920 F.2d 457, 468-470 (7th Cir. 1990) (state law which fails to transfer risk is preempted), *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153-154 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991); *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453, 455-456 (10th Cir. 1989) (state law which failed to transfer risk or satisfy second factor is preempted); *Anschultz v. Connecticut General Life Insurance Company*, 850 F.2d 1467, 1468 (11th Cir. 1988).

conflict, the Ninth Circuit held a state law must meet the "common sense" test and only two of the three parts of the McCarran-Ferguson Act to be saved from preemption. *See Cisneros v. UNUM Life Ins. Co. of America*, 134 F.3d 939, 946 (9th Cir. 1997). In addition, a further conflict exists between the (i) Fifth and Eighth Circuits and (ii) Ninth, Fourth and Tenth Circuits as to the application of the "business of insurance" test. Supreme Court review is necessary to resolve these conflicts.

1. The Common Sense View.

The first step in the Savings Clause analysis is the so-called "common sense view" of the term "regulates insurance," that is, whether the Statute or Interpretations are specifically directed at the insurance industry. *Pilot Life v. Dedeaux*, 481 U.S. 41, 50, 107 S.Ct. 1549, 1554 (1987). The Ninth Circuit's analysis of the "common sense view" is erroneous as a matter of statutory interpretation and is in direct conflict with the analysis of the Fifth and Eighth Circuits. *CIGNA Healthplan of Louisiana, Inc. v. Louisiana*, 82 F.3d 642, 649 (5th Cir. 1996) (common sense test not met because statute applies to Taft-Hartley trusts); *Prudential Insurance Company of America v. National Park*, 154 F.3d 812, 828 (8th Cir. 1998) (common sense test not met because statute extends to providers).

The term "health plan" contained in the Washington Statute is defined by RCW 48.43.005(18) App. 107 as follows:

> (9) "Health Plan" or "Health Benefit Plan" means any policy, contract or agreement offered

> by a Health Carrier to provide, arrange, reimburse, or pay for Health Care Service. . . .

Such definition extends far beyond the insurance industry. First, the Statute is not limited to policies, contracts or agreements to "provide" or "pay for" health services as would be the case in insurance products, but also extends to policies, contracts or arrangements which "arrange" for Health Care Service. Such language is a clear attempt to reach relationships in which the Health Carrier does not function as an insurer, and bears no insurance risk, but merely uses administrative capabilities to design and manage claims administration for plans sponsored and funded by other entities. The law is clear that a state may not indirectly regulate ERISA plans by attempting to regulate the plan administration activities of an entity which provides no insurance to a plan, even if the entity also conducts business as an insurer within the state. *FMC Corp. v. Holliday*, 498 U.S. 52, 64, 111 S.Ct. 403, 411 (1990).

The Ninth Circuit attempts to narrow the statutory definition of the term "arrange" by suggesting that the term means "an active involvement in the actual provision of health care." App. at p. 11. Such a reading is not supported by the legislative history of the Act or by the method by which health services are "arranged" for self-funded plans.[5] A health carrier who is actively providing

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[5] RCW 48.43.045 was originally enacted as part of the 1993 Health Services Act which was not part of the Insurance Code. App. at 64-65. The language was intended to be broad because the Health Services Act intended to make sweeping changes to the availability and delivery of health services. App. at 64.

administrative services to a self-funded plan has "an active involvement in the provision of health care," in the manner described by the Ninth Circuit. For example, a self-insured plan may contract with a health carrier to arrange for a provider network, establish a gatekeeper utilization management structure and to process claims. In such case, the health carrier has clearly "arranged" for services "with an active involvement in the provision of" health care which would not be permissible under RCW 48.43.045. Because the Statute reaches such arrangements where no insurance is involved, it extends beyond the insurance industry.

Just as the Ninth Circuit's attempt to narrow the statutory definition of "provide, arrange, reimburse, or pay for" is flawed, so is the Ninth Circuit's simultaneous attempt to expand the definition of "employer-Sponsored health plan" to include self-funded Taft-Hartley plans, multiple-employer plans and organization-sponsored plans. App. at 11. The term "plan sponsor" is a term of art under ERISA §3(16)(B), 29 U.S.C. §1002(16)(B), App. at 132, with the term "employer sponsor" being defined as

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When the 1993 Health Services Act was repealed, the Alternative Provider Statute was merely renumbered and placed in the Insurance Code, replacing only the reference to the "Uniform Benefits Package" with a reference to the basic health plan. The words "provide, arrange; reimburse or pay" were intended not simply to reach insurance contracts, but to reach agreements by a health service contractor (e.g., a physician clinic) to provide health care services and agreements with third parties to arrange for the provision of health services and the processing of claims. App. at 65. The legislative history of the Statute, therefore, does not support the narrow reading of the Statute suggested by the Ninth Circuit.

an employee benefit plan maintained by a single employer. The fact that the legislature was aware of ERISA and chose a narrowly defined ERISA term when constructing the Alternative Provider Statute does not suggest that some alternative definition was intended, as suggested by the Ninth Circuit. App. at 11. Rather, it suggests that multiple employer and organization-sponsored plans, as well as self-funded Taft-Hartley plans, are *not* exempt from the application of RCW 48.43.045(1) and, therefore, the Statute is fatally overbroad.

Even assuming arguendo that the Statute and Interpretations pass the "common sense" view, they are preempted because they fail to satisfy the criteria developed under the McCarran-Ferguson "business of insurance test."

2. The McCarran-Ferguson Criteria.

Under the McCarran-Ferguson "business of insurance" test, it is necessary to consider three criteria in determining whether the Statute and Interpretations "regulate insurance:" (1) whether there is a transfer or spreading of risk; (2) whether the practice is an integral part of the insured/insurer relationship and (3) whether the practice is limited solely to entities within the insurance industry. *Pilot Life*, 481 U.S. at 48-49, 107 S.Ct. at 1552-53. The Statute and the Interpretations must meet *both* the common sense view and the McCarran-Ferguson criteria must be answered in the affirmative, in order for the Statute and Interpretations to be saved from preemption. *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana*, 82 F.3d 642, 649 (5th Cir. 1996). If the Statute or the

Interpretations fail to satisfy either the common sense view or criteria under the McCarran-Ferguson test then the offending state action must be preempted. As previously indicated, a split has developed between the Circuits as to whether all three criteria must be satisfied or only two out of three of the criteria must be met.

The first McCarran-Ferguson criteria requires that there be risk shifting between the insurer and insured. The Ninth Circuit's analysis, App. at 16, that the treatment of a back injury by a chiropractor is an element of insured risk because a benefit is bestowed on the insured has been rejected by the Eighth Circuit, *National Park*, 154 F.3d at 829-30, and this Court. *Royal Drug, infra.* Such treatment by a particular provider does not shift the insured risk any more than a decision to include or exclude a particular "Dr. Smith" or "Dr. Jones" in a preferred panel shifts the risk. For a subscriber with a covered condition, the shifting of risk occurs at the time the insurance contract is entered. His or her condition is either covered or not covered.

The fallacy of the Ninth Circuit's argument is that it equates "effective treatment for the condition" with the choice of provider. App. at 16. Many different providers can effectively treat the condition under managed care and the choice of how to fulfill the health carrier's obligation through the utilization of a gatekeeper function does not involve the insurance risk but rather the cost of fulfilling the underwriting obligation. As previously indicated, this Court made this very same distinction in a case involving what constituted the scope of the "business of insurance," *Group Life and Health Insurance Company v. Royal Drug Co.*, 440 U.S. 205, 212, 99 S.Ct. 1067,

1074 (1979).[6] Because the Statute and State Interpretations govern the contracts with providers and do not involve the "spreading of risk," the Statute and Interpretations are not "saved" from preemption as a law regulating insurance.

The second McCarran-Ferguson criteria requires that the Statute and Interpretations define the terms of the policy relationship between the insurer and the insured. *Pilot Life*, 481 U.S. at 50, 107 S.Ct. at 1554. In the instant case, the Statute and Interpretations regulate only the terms of the relationship between the carrier and the providers, not between the carrier and its subscribers. Whether a subscriber is or is not covered for a particular condition is not a concern of the Statute and Interpretations. Rather, the focus is solely on which providers the carrier must employ in order to fulfill its obligation to provide such coverage.

Contrary to the Ninth Circuit's analysis, the Alternative Provider Statute does not require every health plan to let every insured make use of alternative medicine. App. at 17. The Act only requires that every category of provider be given the opportunity to join the health plan. If a category of providers does not wish to participate, there is no right in the insured to compel coverage.

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[6] In addition, the statutory provisions extend to self-funded union plans and self-funded plans adopted by trade associations. As previously indicated, in such situations, the Health Carriers may be no more than a third party administrator. As such, they cannot be engaged in the "business of insurance."

Similarly, if the insured's provider of choice is not covered by the plan, there is no right in the insured to compel coverage. The practice of provider contracting is simply not "integral" to the carrier-insured relationship.

To satisfy the third criteria of the McCarran-Ferguson analysis, the Statute and Interpretations must be limited solely to the insurance industry. *Pilot Life*, 481 U.S. at 49, 107 S.Ct. at 1553. It is not enough that the Statute and Interpretations apply to the insurance industry and possibly other parties. The Statute and Interpretations fail the third criteria because they are clearly not limited in application to the insurance industry by their express terms. It is clear that a provider-sponsored or provider-related entity which merely accepts "prepayment" does not necessarily assume the risk which characterizes an insurer. In addition, because the definition of "Health Plans" includes uninsured ERISA plans such as self-funded Taft-Hartley plans and multiple employer plans sponsored, for example, by trade associations, the Statute and Interpretations in question clearly extend beyond the insurance industry to uninsured plans.

In summary, in order for the Statute and Interpretations in question to avoid preemption, they must represent the regulation of insurance under *both* a "common sense" view and criteria of the McCarran-Ferguson test. A split in the Circuits exists as to whether *all* of the McCarran-Ferguson criteria must be met. A split also exists as to whether the regulation of provider relationships is the regulation of insurance within the meaning of

Royal Drug. Certiorari should be granted to resolve these issues.

CONCLUSION

The Ninth Circuit's Opinion conflicts with the ERISA statutory scheme, opinions of this Court and the laws of Third, Fourth, Fifth, Seventh, Eighth, Tenth and Eleventh Circuits. For the foregoing reasons, petitioners urge the Court to grant a Writ of Certiorari, to ensure the uniform regulation of health care plans subject to ERISA.

Respectfully submitted,

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APPENDIX A

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

WASHINGTON PHYSICIANS SERVICE ASSOCIATION; MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON, a health care service contractor; GOOD HEALTH PLAN OF WASHINGTON, a health maintenance organization; PACIFICARE OF WASHINGTON, a health care service contractor; SELECTCARE HEALTH PLANS, a health maintenance; QUALMED WASHINGTON HEALTH PLAN, INC., a health maintenance; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, a health maintenance organization; BLUE CROSS AND BLUE SHIELD OF OREGON, a health care service contractor; GROUP HEALTH COOPERATIVE OF PUGET SOUND, a health maintenance organization; BLUE CROSS OF WASHINGTON AND ALASKA, a health care service; PIERCE COUNTY MEDICAL BUREAU, INC., a health care service; KING COUNTY MEDICAL BLUE SHIELD, a health care service, *Plaintiffs-Appellees,* v. CHRISTINE O. GREGOIRE, in her official capacity as Attorney General for the State of Washington; DEBORAH SENN, in her official capacity as Insurance Commissioner of the State of Washington, *Defendants-Appellants.*	No. 97-35536 D.C. No. CV 96-5850 FDB ORDER AND AMENDED OPINION

Appeal from the United States District Court
for the Western District of Washington
Franklin D. Burgess, District Judge, Presiding

Argued and Submitted
May 7, 1998 – Seattle, Washington

Filed June 18, 1998
Amended August 24, 1998

Before: David R. Thompson and A. Wallace Tashima, Circuit Judges,and Tom Stagg, District Judge.*

Opinion by Judge Tashima

COUNSEL

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*The Honorable Tom Stagg, Senior United States District Judge for the Western District of Louisiana, sitting by designation.

Physicians and Washington State Chiropractic Association.

Gregory B. Stites, Kansas City, Missouri, for *amicus curiae* National Association of Insurance Commissioners.

ORDER

The opinion filed June 18, 1998, is amended as follows:

Immediately following "**III.**", slip opinion at 6104, add the following:

> Having rejected ERISA preemption in this case, we now address the plaintiffs' alternative argument that construing the Act in the way that we have renders it invalid under RCW 48.47.005-.030 (formerly codified at RCW 48.42.060-.080). Those provisions require that any person seeking to establish a mandated health benefit law in Washington must provide the state legislature with a report addressing the social and fiscal impact of the proposed mandated benefit. RCW 48.47.020(1). Plaintiffs contend that these provisions were not complied with in the passage of the Act. Thus, they reason, our interpretation of the Act as a kind of mandated benefit law renders it invalid as a matter of state law.
>
> We reject plaintiffs' argument for two reasons. First, as the movants for summary judgment, the plaintiffs bore the burden of providing sufficient evidence to establish a prima facie case that RCW 48.47.005-.030 were not complied with, *Celotex Corp. v. Catrett*, 477 U.S. 317, 323

(1986). The conclusory affidavits that were submitted on the issue of failure to comply with RCW 48.47.020(1) were not based on first-hand knowledge and were thus insufficient to establish a prima facie case.

Second, and more importantly, RCW 48.47.005-.030 apply only to Washington laws that establish a "mandated health benefit," as that term is defined in RCW 48.47.010(7), *not* as that term might be understood in ERISA case law. RCW 48.47.010(7) defines a "mandated health benefit" as a legal requirement to "(a) Cover a specific health care service or services; (b) cover treatment of a specific condition or conditions; or (c) contract, pay, or reimburse specific categories of health care providers for specific services. . . . " The benefits conferred by the Act are the expanded treatments available to insureds, and the concomitant spreading of risk, due to the increase in the categories of providers able to provide treatment. Obviously, then, subsections (a) and (b) are inapplicable because the Act does not require the coverage of any *specific* health care service or condition. Subsection (c) comes closer, but ultimately fails because of the words "for specific services." Thus, our construction of the Act does not turn it into a "mandated health benefit" law within the meaning of RCW 48.47.010(7); therefore, RCW 48.47.005-.030 do not apply.[3]

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[3] The premise of the plaintiffs' argument that RCW 48.47.005-.030 were violated in the passage of the Act is that such a violation would render the Act invalid as a matter of state law. In light of our conclusion that these provisions do not apply, we need not address the more difficult question of what would happen if they did apply and were not complied with.

IV.

With these amendments, the panel as constituted above has voted to deny the petition for rehearing. Judges Thompson and Tashima have voted to reject the suggestion for rehearing en banc, and Judge Stagg so recommends.

The full court has been advised of the suggestion for rehearing en banc, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The petition for rehearing is denied, and the suggestion for rehearing en banc is rejected.

OPINION

TASHIMA, Circuit Judge:

More than a decade ago, the Supreme Court acknowledged the growing trend among the states to require health insurers to offer certain benefits as part of every health insurance policy they sell. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 728-29 (1985). In *Metropolitan Life*, the Court upheld Massachusetts' once-controversial requirement that insurers offer some limited form of mental-health protection. That trend continues and continues to generate controversy. In this case, we must decide whether Washington's so-called Alternative Provider Statute is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* The Alternative Provider Statute, or "every category of provider" law, requires that health maintenance organizations ("HMOs") and health care

service contractors ("HCSCs") cover acupuncture, massage therapy, naturopathy, chiropractic services, and a variety of other "alternative" medical treatments. We conclude that the Washington law is merely the latest variation in an oft-repeated theme, and we reject ERISA preemption.

I.

In 1995, the Washington legislature effected sweeping changes to the state's regulation of health insurance, and the Alternative Provider Statute (the "Act") is one part of that reform. The Act itself is relatively short:

> Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:
>
> (1) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that:
>
> (a) The provision of such health services or care is within the health care providers' permitted scope of practice; and
>
> (b) The providers agree to abide by standards related to:
>
> (i) Provision, utilization review, and cost containment of health services;
>
> (ii) Management and administrative procedures; and
>
> (iii) Provision of cost-effective and clinically efficacious health services.

RCW 48.43.045(1).

The terms used in the Act are mostly defined in RCW 48.43.005 ("Definitions"). In particular, a "health carrier" or "carrier" means a disability insurer, a health care service contractor, or a health maintenance organization. RCW 48.43.005(8). And a "health plan" or "health benefit plan" means "any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service," subject to a few exceptions. RCW 48.43.005(9). "Provider" is undefined in the statute, but refers to a doctor, dentist, acupuncturist, or other health care provider.

Thus, the Act forces every carrier (HMOs, disability insurers) to allow every insured to choose from an expanded list of providers (acupuncturists, massage therapists) for medical conditions covered by the insured's policy. The Act does not force any carrier to contract with any particular provider (*e.g.*, John Smith, M.D.) but merely forbids a carrier from excluding an entire category of licensed providers (*e.g.*, all chiropractors or all naturopaths) from its policy.

The plaintiffs, a collection of HMOs and HCSCs, sought a declaratory judgment that the Act is preempted by ERISA and an injunction against its further enforcement. On cross motions for summary judgment, the district court ruled for the plaintiffs, finding that the Act "relates to" an employee benefit plan under ERISA, and that it is not saved as a regulation of insurance. *Washington Physicians Serv. Ass'n v. Gregoire*, 967 F.Supp. 424, 427-31 (W.D. Wash. 1997). The state appeals, and we reverse.

II.

ERISA provides for the federal regulation of employee welfare benefit plans. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650-51 (1995). To ensure that such regulation would remain "exclusively a federal concern," *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981), Congress enacted a broad preemption provision, which states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . . " 29 U.S.C. § 1144(a). An exception is contained in 29 U.S.C. § 1144(b)(2)(A): "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

Thus, our ERISA inquiry is a two-step process. We first ask whether the Act "relates to" an employee benefit plan; and if it does, we then decide whether it is exempted from preemption by the savings clause in § 1144(b)(2)(A). We conclude that the Act escapes ERISA preemption at the first step, but since we also think it would be saved as a regulation of insurance, we explain the second step as well.

A. Relates To

In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), the Supreme Court explained that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97. The Court has since elaborated that in determining whether a "connection" exists between a state law

and an ERISA plan, courts must consider whether the law requires particular benefit structures or imposes administrative burdens on a plan. *Travelers*, 514 U.S. at 658. A law does not "relate to" an ERISA plan merely because it produces indirect economic effects that happen to influence the shopping choices that the benefit plan must make. *Id.* at 661. Rather, a generally applicable state law that does not specifically target ERISA plans is preempted only if it produces such acute economic effects "as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers. . . . " *Id.* at 668.

We can dispense with the most obvious way in which the Washington law might "relate to" an employee benefit plan, namely, by referring to and acting directly upon such plans. The statute operates directly upon "health plans," but it also makes clear that this term refers to the plan offered by the health carrier (*e.g.*, an HMO), not the benefit plan offered by the employer. RCW 48.43.005(9)(i). Further narrowing the law's application is the definition of a "health carrier" to include only a disability insurer, an HCSC or an HMO, and to *exclude* employer-sponsored, self-funded health plans. RCW 48.43.005(9). In plain English, if an HMO wants to sell health insurance in Washington, it must comply with the Act regardless of to whom it sells insurance. Thus, if ABC Corp. wishes to offer its employees health insurance by purchasing an HMO plan, it will find that all of the options available to it in the market cover alternative medicine because it is simply not legal for an HMO to offer any other kind of plan. By contrast, if ABC Corp. were itself the health self-insurer for its employees, the Act would not apply at all,

and ABC Corp. could structure its benefits in any way it chose. Accordingly, the Act does not operate directly on the ERISA plan, but only indirectly by limiting the options available in the market – if the plan should choose to purchase health insurance on the market, rather than providing it itself or not providing it at all.

Arguably, there is a textual ambiguity in the Act about whether its definition of "health plan" inadvertently includes some specialized kinds of ERISA plans. We say "inadvertently" because the exclusion of self-funded plans in RCW 48.43.005(9)(i) is quite obviously intended to save the Act from ERISA preemption. Notwithstanding this exclusion, the plaintiffs argue that the Washington legislature was not careful enough in drafting the law, and they assert that the Act does operate directly upon some kinds of ERISA plans – in particular, contracts for administrative services performed for a self-insured employer, multiple-employer and organization-sponsored plans, and self-funded Taft-Hartley plans.

We are unpersuaded by the plaintiffs' broad reading of the Act. A health carrier's contract to perform only administrative services for a self-insured employer is not within the ambit of the Act. A "health plan" is defined as "any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service." RCW 48.43.005(9). A health carrier that merely performs administrative functions for a self-insured employer clearly does not "provide," "reimburse," or "pay" for health care service. Possibly it "arrange[s] . . . for health care service" by performing purely administrative tasks – but when a vague word

such as "arrange" is placed next to "provide," "reimburse," and "pay," we think a more active involvement in the actual provision of health care is meant. Similarly, we are inclined to read the exclusion in RCW 48.43.005(9)(i) broadly to exclude self-funded Taft-Hartley plans, multiple-employer plans and organization-sponsored plans. Accordingly, we conclude that the Act does not operate directly on any ERISA plans.

With this reading of the Act, the instant case is easily distinguished from the numerous cases that have found a "reference" to ERISA plans in a state's regulation of health plans. In general, the state laws in these other cases all included ERISA plans in the definition of "health plan" or otherwise expressly referred to ERISA plans. *See FMC Corp. v. Holliday,* 498 U.S. 52, 59 (1990); *Metropolitan Life,* 471 U.S. at n.11; *Texas Pharmacy Ass'n v. Prudential Ins. Co.,* 105 F.3d 1035, 1038 (5th Cir.), *cert. denied,* 118 S. Ct. 75 (1997); *CIGNA Healthplan of La., Inc. v. Louisiana,* 82 F.3d 642, 647 (5th Cir.), *cert. denied,* 117 S. Ct. 387 (1996). *See also Blue Cross and Blue Shield v. Nielsen,* 917 F.Supp. 1532, 1537 (N.D. Ala. 1996), *questions certified,* 116 F.3d 1406 (11th Cir. 1997); *Hayden v. Blue Cross and Blue Shield,* 843 F.Supp. 1427, 1428 n.2, 1433 (M.D. Ala. 1994); *General Motors Corp. v. Caldwell,* 647 F.Supp. 585, 586 (N.D. Ga. 1986);[1] *Blue Cross and Blue Shield v. Peacock's Apothecary, Inc.,* 567 F.Supp. 1258, 1264 (N.D. Ala. 1983). Because the Act is different from these other state laws in that it does

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[1] In that case, although the court characterized the law as only indirectly affecting ERISA plans, *General Motors,* 647 F.Supp. at 587, it is clear from the court's summary of the statute that the law operated directly on ERISA plans. *See id.* at 586.

not expressly refer to ERISA plans and does not operate directly on them, we do not find this string of precedent relevant. We hold that the Act does not have a "reference" to ERISA plans.

We also do not find a "connection to" ERISA plans. The plaintiffs' argue that the Act is connected to ERISA plans because it supposedly affects the structure of these plans, imposes an administrative burden on them, and controls administrative choices about with whom to contract. The plaintiffs are correct that if the Act did these things, it would have a "connection" to ERISA plans. *Travelers*, 514 U.S. at 656-57. The problem for the plaintiffs, however, is their inability to distinguish between the plan and the health carrier – a distinction that, as we have noted, is important in the Act. We read the Act to operate only on health carriers that are distinct from ERISA plans, and with such a reading, it is simply false to say that the Act imposes an administrative burden on the plan or that it dictates certain benefit structures. The Act does not require employers to provide any particular welfare benefit to employees, and it does not impose any burden on the plan in administering any benefits it chooses to provide. All of these burdens fall on the health carrier.

In the end, what saves the Act from ERISA preemption is that it does not have anything to do with employee benefit plans in particular. It is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy. The Act regulates health insurance in a broad and neutral way, and *only* when that insurance is not provided by the plan itself. The mere fact that many ERISA plans choose to buy health insurance for their plan members does not cause a

regulation of health insurance automatically to "relate to" an employee benefit plan – just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to "relate to" employee benefit plans. After *Travelers*, ERISA plans no longer have a Midas touch that allows them to deregulate every product they choose to buy as part of their employee benefit plan. *See Travelers*, 514 U.S. at 661 ("[N]othing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern. . . . ").[2] *See also De Buono v. NYSA-ILA Med. and Clinical Servs.*, 117 S. Ct. 1747, 1749 (1997) (holding that "hospitals operated by ERISA plans are subject to the same laws as other hospitals").

Accordingly, the mere fact that the Act regulates a product that ERISA plans often choose to buy does not mean that it "relates to" an ERISA plan. The district court erred in holding that the Act "relates to" ERISA benefit plans. *Washington Physicians Serv. Ass'n*, 967 F. Supp. at 427, 430.

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[2] Indeed, on remand, the Second Circuit, noting that the Supreme Court had restricted the scope of ERISA preemption in *Travelers*, repudiated its prior holdings that any law that targeted the health care industry automatically related to an ERISA plan. *Travelers Ins. Co. v. Pataki*, 63 F.3d 89, 94 (2d Cir. 1995).

B. The Savings Clause

Alternatively, even were we to find that the Act "relate[d] to" an employee benefit plan, we would still reject ERISA preemption. 29 U.S.C. § 1144(b)(2)(A) saves from preemption state laws that regulate insurance. In our opinion, that is what the Act does.

In *Metropolitan Life*, the Court delineated the test for when a state law is saved as a regulation of insurance. First, the law must fit a common-sense understanding of insurance regulation. 471 U.S. at 740-42. Second, the law must be within the business of insurance under the *McCarran-Ferguson Act*, 15 U.S.C. §§ 1011-15. *Id.* at 740-44. *See also Cisneros v. Unum Life Ins. Co.*, 134 F.3d 939, 944-45 (9th Cir. 1998) (summarizing the savings clause test).

1. Common Sense

In order to be within the common-sense definition of insurance regulation, "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). Beyond that, however, states have considerable latitude in regulating insurance. A state law that "is in reality a health law that merely operates on insurance contracts to accomplish its end," is perfectly permissible. *Metropolitan Life*, 471 U.S. at 741. ERISA does not prefer traditional insurance regulations over innovative ones – all are equally saved from preemption. *Id.* Additionally, laws that require insurance companies to provide certain benefits as part of their insurance coverage are within the common-sense definition of insurance regulation. *Id.* at 742.

The Washington law is "specifically directed" toward the insurance industry, *Pilot Life*, 481 U.S. at 50, because it operates directly on HMOs and HCSCs, entities that are engaged in the business of health insurance. "The primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979), citing 1 **G. Couch, Cyclopedia of Insurance Law** § 1:3 (2d ed. 1959) ("It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it."). The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, *Anderson v. Humana, Inc.*, 24 F.3d 889, 890 (7th Cir. 1994), but this is a distinction without a difference. *Metropolitan Life*, 471 U.S. at 741 (explaining that nothing in ERISA "purports to distinguish between traditional and innovative insurance laws"); *Klamath-Lake Pharmaceutical Ass'n v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1286-87 (9th Cir. 1983). In the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.

Conceding that the Act regulates the correct entities, the plaintiffs nonetheless contend that it is not a regulation of insurance *per se*. In their view, the Act regulates the relationship between the carrier and the provider

rather than the relationship between the carrier and the insured.

Because insurance is the business of spreading risk, *Royal Drug*, 440 U.S. at 205, a state law that regulates the relationship between a carrier and a provider without affecting the risk borne by the insured is outside the definition of insurance regulation. *Id.* at 213-14; *Hahn v. Oregon Physicians Serv.*, 689 F.2d 840, 843-44 (9th Cir. 1982). On the other hand, a state law that mandates certain benefits in an insurance policy necessarily affects the risk borne by the insured and is within the definition of insurance regulation. *Metropolitan Life*, 471 U.S. at 743; *Klamath-Lake*, 701 F.2d at 1286-87. The present case therefore turns on whether the Act confers a benefit on insureds (in the sense of affecting the risk the insured bears), or whether it merely regulates the carrier-provider relationship, a matter of indifference to the insured.

In our opinion, the Act confers a benefit on insureds by expanding the treatments that their health carriers must provide or pay for. Before the Act, if an insured had a medical condition that could not be effectively treated by traditional medicine (*e.g.*, lower back pain), but could be treated by alternative medicine (*e.g.*, by a chiropractor), the insured bore the risk that he would need this alternative medical treatment. Now, a substantial portion of Washington's population bears that risk because every health insurance policy must cover that alternative treatment. *Metropolitan Life*, 471 U.S. at 743.

It is irrelevant that the Act accomplishes its risk-spreading function in an unusual way. Risk-spreading is a concept that involves more than the mere selection of

certain medical conditions for coverage. The degree of risk-spreading between the insured and the carrier also depends on what kinds of treatments the policy agrees to pay for, what kinds of deductibles it will charge, and whether there will be a cap on overall expenses. *See Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir. 1993) ("[T]reatment and cost are important components of health insurance.") A state law, for instance, that outlawed deductibles and co-payments would have a massive effect on risk-spreading, even though it did not alter the medical conditions covered by the policy. Similarly, a law such as the Act, that mandates expanded treatments for covered conditions also affects risk-spreading by shifting more risk to the insurer (*i.e.*, the risk that these treatments will be needed). Thus, despite the unusual form of the Act, it is emphatically a regulation of risk-spreading.

The plaintiffs focus too much on the phrasing of the Act in their effort to characterize it as affecting only the carrier-provider relationship, not the carrier-insured relationship. It is true that the Act says that every health plan must permit "every category of health provider to provide health services or care for conditions included in the basic health plan. . . . " RCW 48.43.045(1). But the key word is "category," not "provider." The statute does not require any carrier to contract or deal with any particular provider; it merely forbids a carrier from excluding a complete *type* of provider. By contrast, the Act does require *every* health plan to let *every* insured make use of alternative medical treatments. Although this requirement confers a residual benefit on providers as a class, its primary benefit is to the insured. *See Stuart Circle*, 995

F.2d at 504 ("[A]lthough facially the statute only directly affects providers, it indirectly affects the insured's choice of provider and the consequent costs to the insured if he or she deems an excluded provider to be better qualified for treatment of a specific illness or accident. In this way it affects the risk that an insured must bear.")

Another way to see how the Act confers a benefit on insureds is to contrast it with the "any willing provider" statutes that some states have enacted. An "any willing provider" law requires a health carrier to allow an insured to see any doctor willing to abide by the terms of the insurance plan and willing to provide only those treatments specified in the plan. Such a statute does not expand the conditions covered by the policy, *nor* does it expand the types of treatments available under the policy. *E.g., Texas Pharmacy,* 105 F.3d at 1041; *CIGNA,* 82 F.3d at 644 n.2. Some courts have taken the view that an "any willing provider" statute does not affect the risk borne by the insured, reasoning that it merely regulates the carrier-provider relationship. *Prudential Ins. Co. v. National Park Med. Ctr., Inc.,* 964 F.Supp. 1285, 1298 (E.D. Ark. 1997); *Nielsen,* 917 F.Supp. at 1541; *Hayden,* 843 F.Supp. at 1435-36. Other courts have disagreed and held that an "any willing provider" statute does spread risk. *See Texas Pharmacy,* 105 F.3d at 1041; *Stuart Circle,* 995 F.2d at 503; *Blue Cross and Blue Shield v. Bell,* 798 F.2d 1331, 1334-35 (10th Cir. 1986). Regardless of the view one takes of an "any willing provider" statute (and we express no opinion on that), the Act even more clearly affects the carrier-insured relationship. The Act works a substantive alteration of the insurance policy and mandates that the insurer cover an expanded list of treatments. It therefore

spreads the risk that an insured may need alternative medical treatments to heal his or her medical condition. Accordingly, the Act is within the common-sense definition of insurance. *Metropolitan Life*, 471 U.S. at 743.

2. The McCarran-Ferguson Test

The second prong of the savings clause test is whether the law meets the McCarran-Ferguson test for the business of insurance. *Cisneros*, 134 F.3d at 944-47. There are three factors in the McCarran-Ferguson test: First, does the law spread risk? Second, does the law regulate an integral part of the policy relationship between the carrier and the insured? Third, is the law limited to entities within the insurance industry? *Id.* at 945 (quoting *Metropolitan Life*, 471 U.S. at 743). In this circuit, "the McCarran-Ferguson factors are simply relevant considerations or guideposts, not separate essential elements of a three-part test that must each be satisfied for a law to escape preemption." *Id.* at 946.

We face no new arguments here. We have already discussed the first factor, risk spreading, under the "common-sense" understanding of insurance. As to the second – whether the Act regulates an integral part of the carrier-insured policy relationship – we again refer to the previous section of the opinion. Because the Act does spread risk and therefore does confer a benefit on insureds, it does regulate an integral part of the carrier-insured relationship. *Metropolitan Life*, 471 U.S. at 743.

The third prong – whether the Act is limited to entities within the insurance industry – once again takes us back to whether the Act reaches some self-insured

ERISA plans, which by definition are not within the insurance industry. 29 U.S.C. § 1144(b)(2)(B). As we have already stated, we think it does not.

Accordingly, the Act satisfies all three prongs of the McCarran-Ferguson test and falls within the savings clause as a regulation of insurance. The district court erred when it held to the contrary. *Washington Physicians Serv. Ass'n*, 967 F.Supp. 427-31.

III.

Having rejected ERISA preemption in this case, we now address the plaintiffs' alternative argument that construing the Act in the way that we have renders it invalid under RCW 48.47.005-.030 (formerly codified at RCW 48.42.060-.080). Those provisions require that any person seeking to establish a mandated health benefit law in Washington must provide the state legislature with a report addressing the social and fiscal impact of the proposed mandated benefit. RCW 48.47.020(1). Plaintiffs contend that these provisions were not complied with in the passage of the Act. Thus, they reason, our interpretation of the Act as a kind of mandated benefit law renders it invalid as a matter of state law.

We reject plaintiffs' argument for two reasons. First, as the movants for summary judgment, the plaintiffs bore the burden of providing sufficient evidence to establish a prima facie case that RCW 48.47.005-.030 were not complied with, *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). The conclusory affidavits that were submitted on the issue of failure to comply with RCW 48.47.020(1) were

not based on first-hand knowledge and were thus insufficient to establish a prima facie case.

Second, and more importantly, RCW 48.47.005-.030 apply only to Washington laws that establish a "mandated health benefit," as that term is defined in RCW 48.47.010(7), *not* as that term might be understood in ERISA case law. RCW 48.47.010(7) defines a "mandated health benefit" as a legal requirement to "(a) Cover a specific health care service or services; (b) cover treatment of a specific condition or conditions; or (c) contract, pay, or reimburse specific categories of health care providers for specific services. . . . " The benefits conferred by the Act are the expanded treatments available to insureds, and the concomitant spreading of risk, due to the increase in the categories of providers able to provide treatment. Obviously, then, subsections (a) and (b) are inapplicable because the Act does not require the coverage of any *specific* health care service or condition. Subsection (c) comes closer, but ultimately fails because of the words "for specific services." Thus, our construction of the Act does not turn it into a "mandated health benefit" law within the meaning of RCW 48.47.010(7); therefore, RCW 48.47.005-.030 do not apply.[3]

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[3] The premise of the plaintiffs' argument that RCW 48.47.005-.030 were violated in the passage of the Act is that such a violation would render the Act invalid as a matter of state law. In light of our conclusion that these provisions do not apply, we need not address the more difficult question of what would happen if they did apply and were not complied with.

IV.

The district court's grant of summary judgment in favor of the plaintiffs is reversed, and the case is remanded with instructions to enter summary judgment for the defendants.

REVERSED and REMANDED.

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

WASHINGTON PHYSICIANS SERVICE ASSOCIATION; MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON, a health care service contractor; GOOD HEALTH PLAN OF WASHINGTON, a health maintenance organization; PACIFICARE OF WASHINGTON, a health care service contractor; SELECTCARE HEALTH PLANS, a health maintenance; QUALMED WASHINGTON HEALTH PLAN, INC., a health maintenance; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, a health maintenance organization; BLUE CROSS AND BLUE SHIELD OF OREGON, a health care service contractor; GROUP HEALTH COOPERATIVE OF PUGET SOUND, a health maintenance organization; BLUE CROSS OF WASHINGTON AND ALASKA, a health care service; PIERCE COUNTY MEDICAL BUREAU, INC., a health care service; KING COUNTY MEDICAL BLUE SHIELD, a health care service, *Plaintiffs-Appellees,*	No. 97-35536 D.C. No. CV 96-5850 FDB OPINION

v.

CHRISTINE O. GREGOIRE, in her official capacity as Attorney General for the State of Washington; Deborah Senn, in her official capacity as Insurance Commissioner of the State of Washington,

Defendants-Appellants.

Appeal from the United States District Court
for the Western District of Washington
Franklin D. Burgess, District Judge, Presiding

Argued and Submitted
May 7, 1998 – Seattle, Washington

Filed June 18, 1998

Before: David R. Thompson and A. Wallace Tashima, Circuit Judges, and Tom Stagg, District Judge.*

Opinion by Judge Tashima

COUNSEL

Christine O. Gregoire, Attorney General of Washington, H. Lee Roussel, Assistant Attorney General, Olympia, Washington, for the defendants-appellants.

Richard J. Birmingham, Birmingham Thorson & Barnett, P.C., Seattle, Washington, for the plaintiffs-appellees.

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*The Honorable Tom Stagg, Senior United States District Judge for the Western District of Louisiana, sitting by designation.

Paul C. Adair, United States Department of Labor, Office of the Solicitor, Washington, D.C., for *amicus curiae* United States Secretary of Labor.

Arthur N. Lerner, Michaels Wishner & Bonner, P.C., Washington, D.C., for *amicus curiae* American Association of Health Plans, Inc.

Jonathan P. Meier, Sirianni & Youtz, Seattle, Washington, for *amici curiae* Washington Association of Naturopathic Physicians and Washington State Chiropractic Association.

Gregory B. Stites, Kansas City, Missouri, for *amicus curiae* National Association of Insurance Commissioners.

OPINION

TASHIMA, Circuit Judge:

More than a decade ago, the Supreme Court acknowledged the growing trend among the states to require health insurers to offer certain benefits as part of every health insurance policy they sell. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 728-29 (1985). In *Metropolitan Life*, the Court upheld Massachusetts' once-controversial requirement that insurers offer some limited form of mental-health protection. That trend continues and continues to generate controversy. In this case, we must decide whether Washington's so-called Alternative Provider Statute is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.* The Alternative Provider Statute, or "every category of provider" law, requires that health maintenance organizations ("HMOs") and health care

service contractors ("HCSCs") cover acupuncture, massage therapy, naturopathy, chiropractic services, and a variety of other "alternative" medical treatments. We conclude that the Washington law is merely the latest variation in an oft-repeated theme, and we reject ERISA preemption.

I.

In 1995, the Washington legislature effected sweeping changes to the state's regulation of health insurance, and the Alternative Provider Statute (the "Act") is one part of that reform. The Act itself is relatively short:

> Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:
>
> (1) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that:
>
> (a) The provision of such health services or care is within the health care providers' permitted scope of practice; and
>
> (b) The providers agree to abide by standards related to:
>
> (i) Provision, utilization review, and cost containment of health services;
>
> (ii) Management and administrative procedures; and
>
> (iii) Provision of cost-effective and clinically efficacious health services.

RCW 48.43.045(1).

The terms used in the Act are mostly defined in RCW 48.43.005 ("Definitions"). In particular, a "health carrier" or "carrier" means a disability insurer, a health care service contractor, or a health maintenance organization. RCW 48.43.005(8). And a "health plan" or "health benefit plan" means "any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service," subject to a few exceptions. RCW 48.43.005(9). "Provider" is undefined in the statute, but refers to a doctor, dentist, acupuncturist, or other health care provider.

Thus, the Act forces every carrier (HMOs, disability insurers) to allow every insured to choose from an expanded list of providers (acupuncturists, massage therapists) for medical conditions covered by the insured's policy. The Act does not force any carrier to contract with any particular provider (*e.g.*, John Smith, M.D.) but merely forbids a carrier from excluding an entire category of licensed providers (*e.g.*, all chiropractors or all naturopaths) from its policy.

The plaintiffs, a collection of HMOs and HCSCs, sought a declaratory judgment that the Act is preempted by ERISA and an injunction against its further enforcement. On cross motions for summary judgment, the district court ruled for the plaintiffs, finding that the Act "relates to" an employee benefit plan under ERISA, and that it is not saved as a regulation of insurance. *Washington Physicians Serv. Ass'n v. Gregoire*, 967 F.Supp. 424, 427-31 (W.D.Wash.1997). The state appeals, and we reverse.

II.

ERISA provides for the federal regulation of employee welfare benefit plans. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650-51, (1995). To ensure that such regulation would remain "exclusively a federal concern," *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523, (1981), Congress enacted a broad preemption provision, which states that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan. . . . " 29 U.S.C. § 1144(a). An exception is contained in 29 U.S.C. § 1144(b)(2)(A): "[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

Thus, our ERISA inquiry is a two-step process. We first ask whether the Act "relates to" an employee benefit plan; and if it does, we then decide whether it is exempted from preemption by the savings clause in § 1144(b)(2)(A). We conclude that the Act escapes ERISA preemption at the first step, but since we also think it would be saved as a regulation of insurance, we explain the second step as well.

A. Relates To

In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), the Supreme Court explained that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Id.* at 96-97. The Court has since elaborated that in determining whether a "connection" exists between a state law

and an ERISA plan, courts must consider whether the law requires particular benefit structures or imposes administrative burdens on a plan. *Travelers*, 514 U.S. at 658. A law does not "relate to" an ERISA plan merely because it produces indirect economic effects that happen to influence the shopping choices that the benefit plan must make. *Id.* at 661. Rather, a generally applicable state law that does not specifically target ERISA plans is preempted only if it produces such acute economic effects "as to force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers. . . . " *Id.* at 668.

We can dispense with the most obvious way in which the Washington law might "relate to" an employee benefit plan, namely, by referring to and acting directly upon such plans. The statute operates directly upon "health plans," but it also makes clear that this term refers to the plan offered by the health carrier (*e.g.*, an HMO), not the benefit plan offered by the employer. RCW 48.43.005(9)(i). Further narrowing the law's application is the definition of a "health carrier" to include only a disability insurer, an HCSC or an HMO, and to *exclude* employer-sponsored, self-funded health plans. RCW 48.43.005(9). In plain English, if an HMO wants to sell health insurance in Washington, it must comply with the Act regardless of to whom it sells insurance. Thus, if ABC Corp. wishes to offer its employees health insurance by purchasing an HMO plan, it will find that all of the options available to it in the market cover alternative medicine because it is simply not legal for an HMO to offer any other kind of plan. By contrast, if ABC Corp. were itself the health self-insurer for its employees, the Act would not apply at all,

and ABC Corp. could structure its benefits in any way it chose. Accordingly, the Act does not operate directly on the ERISA plan, but only indirectly by limiting the options available in the market – if the plan should choose to purchase health insurance on the market, rather than providing it itself or not providing it at all.

Arguably, there is a textual ambiguity in the Act about whether its definition of "health plan" inadvertently includes some specialized kinds of ERISA plans. We say "inadvertently" because the exclusion of self-funded plans in RCW 48.43.005(9)(i) is quite obviously intended to save the Act from ERISA preemption. Notwithstanding this exclusion, the plaintiffs argue that the Washington legislature was not careful enough in drafting the law, and they assert that the Act does operate directly upon some kinds of ERISA plans – in particular, contracts for administrative services performed for a self-insured employer, multiple-employer and organization-sponsored plans, and self-funded Taft-Hartley plans.

We are unpersuaded by the plaintiffs' broad reading of the Act. A health carrier's contract to perform only administrative services for a self-insured employer is not within the ambit of the Act. A "health plan" is defined as "any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care service." RCW 48.43.005(9). A health carrier that merely performs administrative functions for a self-insured employer clearly does not "provide," "reimburse," or "pay" for health care service. Possibly it "arrange[s] . . . for health care service" by performing purely administrative tasks – but when a vague word

such as "arrange" is placed next to "provide," "reimburse," and "pay," we think a more active involvement in the actual provision of health care is meant. Similarly, we are inclined to read the exclusion in RCW 48.43.005(9)(i) broadly to exclude self-funded Taft-Hartley plans, multiple-employer plans and organization-sponsored plans. Accordingly, we conclude that the Act does not operate directly on any ERISA plans.

With this reading of the Act, the instant case is easily distinguished from the numerous cases that have found a "reference" to ERISA plans in a state's regulation of health plans. In general, the state laws in these other cases all included ERISA plans in the definition of "health plan" or otherwise expressly referred to ERISA plans. *See FMC Corp. v. Holliday*, 498 U.S. 52, 59 (1990); *Metropolitan Life*, 471 U.S. at n. 11; *Texas Pharmacy Ass'n v. Prudential Ins. Co.*, 105 F.3d 1035, 1038 (5th Cir.), *cert. denied*, 118 S. Ct. 75 (1997); *CIGNA Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 647 (5th Cir.), *cert. denied*, 117 S. Ct. 387 (1996). *See also Blue Cross and Blue Shield v. Nielsen*, 917 F.Supp. 1532, 1537 (N.D. Ala. 1996), *questions certified*, 116 F.3d 1406 (11th Cir.1997); *Hayden v. Blue Cross and Blue Shield*, 843 F.Supp. 1427, 1428 n.2, 1433 (M.D.Ala.1994); *General Motors Corp. v. Caldwell*, 647 F.Supp. 585, 586 (N.D.Ga.1986);[1] *Blue Cross and Blue Shield v. Peacock's Apothecary, Inc.*, 567 F.Supp. 1258, 1264 (N.D.Ala.1983). Because the Act is different from these other state laws in

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[1] In that case, although the court characterized the law as only indirectly affecting ERISA plans, *General Motors*, 647 F.Supp. at 587, it is clear from the court's summary of the statute that the law operated directly on ERISA plans. *See id.* at 586.

that it does not expressly refer to ERISA plans and does not operate directly on them, we do not find this string of precedent relevant. We hold that the Act does not have a "reference" to ERISA plans.

We also do not find a "connection to" ERISA plans. The plaintiffs' argue that the Act is connected to ERISA plans because it supposedly affects the structure of these plans, imposes an administrative burden on them, and controls administrative choices about with whom to contract. The plaintiffs are correct that if the Act did these things, it would have a "connection" to ERISA plans. *Travelers*, 514 U.S. at 656-57. The problem for the plaintiffs, however, is their inability to distinguish between the plan and the health carrier – a distinction that, as we have noted, is important in the Act. We read the Act to operate only on health carriers that are distinct from ERISA plans, and with such a reading, it is simply false to say that the Act imposes an administrative burden on the plan or that it dictates certain benefit structures. The Act does not require employers to provide any particular welfare benefit to employees, and it does not impose any burden on the plan in administering any benefits it chooses to provide. All of these burdens fall on the health carrier.

In the end, what saves the Act from ERISA preemption is that it does not have anything to do with employee benefit plans in particular. It is merely one of many state laws that regulates one of many products that an employee benefit plan might choose to buy. The Act regulates health insurance in a broad and neutral way, and *only* when that insurance is not provided by the plan itself. The mere fact that many ERISA plans choose to buy health insurance for their plan members does not cause a

regulation of health insurance automatically to "relate to" an employee benefit plan – just as a plan's decision to buy an apple a day for every employee, or to offer employees a gym membership, does not cause all state regulation of apples and gyms to "relate to" employee benefit plans. After *Travelers*, ERISA plans no longer have a Midas touch that allows them to deregulate every product they choose to buy as part of their employee benefit plan. *See Travelers*, 514 U.S. at 661, ("[N]othing in the language of the Act or the context of its passage indicates that Congress chose to displace general health care regulation, which historically has been a matter of local concern. . . . ").[2] *See also De Buono v. NYSA-ILA Med. and Clinical Servs.*, 117 S. Ct. 1747, 1749 (1997) (holding that "hospitals operated by ERISA plans are subject to the same laws as other hospitals").

Accordingly, the mere fact that the Act regulates a product that ERISA plans often choose to buy does not mean that it "relates to" an ERISA plan. The district court erred in holding that the Act "relates to" ERISA benefit plans. *Washington Physicians Serv. Ass'n*, 967 F.Supp. at 427, 430.

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[2] Indeed, on remand, the Second Circuit, noting that the Supreme Court had restricted the scope of ERISA preemption in *Travelers*, repudiated its prior holdings that any law that targeted the health care industry automatically related to an ERISA plan. *Travelers Ins. Co. v. Pataki*, 63 F.3d 89, 94 (2d Cir.1995).

B. The Savings Clause

Alternatively, even were we to find that the Act "relate[d] to" an employee benefit plan, we would still reject ERISA preemption. 29 U.S.C. § 1144(b)(2)(A) saves from preemption state laws that regulate insurance. In our opinion, that is what the Act does.

In *Metropolitan Life*, the Court delineated the test for when a state law is saved as a regulation of insurance. First, the law must fit a common-sense understanding of insurance regulation. 471 U.S. at 740-42. Second, the law must be within the business of insurance under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15. *Id.* at 740-44. *See also Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939, 944-45 (9th Cir.1998) (summarizing the savings clause test).

1. Common Sense

In order to be within the common-sense definition of insurance regulation, "a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). Beyond that, however, states have considerable latitude in regulating insurance. A state law that "is in reality a health law that merely operates on insurance contracts to accomplish its end," is perfectly permissible. *Metropolitan Life*, 471 U.S. at 741. ERISA does not prefer traditional insurance regulations over innovative ones – all are equally saved from pre-emption. *Id.* Additionally, laws that require insurance companies to provide certain benefits as part of their

insurance coverage are within the common-sense definition of insurance regulation. *Id.* at 742.

The Washington law is "specifically directed" toward the insurance industry, *Pilot Life*, 481 U.S. at 50, because it operates directly on HMOs and HCSCs, entities that are engaged in the business of health insurance. "The primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979), citing 1 **G. Couch, Cyclopedia of Insurance Law** § 1:3 (2d ed. 1959). ("It is characteristic of insurance that a number of risks are accepted, some of which involve losses, and that such losses are spread over all the risks so as to enable the insurer to accept each risk at a slight fraction of the possible liability upon it."). The only distinction between an HMO (or HCSC) and a traditional insurer is that the HMO provides medical services directly, while a traditional insurer does so indirectly by paying for the service, *Anderson v. Humana, Inc.*, 24 F.3d 889, 890 (7th Cir.1994), but this is a distinction without a difference. *Metropolitan Life*, 471 U.S. at 741, (explaining that nothing in ERISA "purports to distinguish between traditional and innovative insurance laws"); *Klamath-Lake Pharmaceutical Ass'n v. Klamath Med. Serv. Bureau*, 701 F.2d 1276, 1286-87 (9th Cir.1983). In the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.

Conceding that the Act regulates the correct entities, the plaintiffs nonetheless contend that it is not a regulation of insurance *per se*. In their view, the Act regulates

the relationship between the carrier and the provider rather than the relationship between the carrier and the insured.

Because insurance is the business of spreading risk, *Royal Drug*, 440 U.S. at 205, a state law that regulates the relationship between a carrier and a provider without affecting the risk borne by the insured is outside the definition of insurance regulation. *Id.* at 213-14; *Hahn v. Oregon Physicians Serv.*, 689 F.2d 840, 843-44 (9th Cir.1982). On the other hand, a state law that mandates certain benefits in an insurance policy necessarily affects the risk borne by the insured and is within the definition of insurance regulation. *Metropolitan Life*, 471 U.S. at 743; *Klamath-Lake*, 701 F.2d at 1286-87. The present case therefore turns on whether the Act confers a benefit on insureds (in the sense of affecting the risk the insured bears), or whether it merely regulates the carrier-provider relationship, a matter of indifference to the insured.

In our opinion, the Act confers a benefit on insureds by expanding the treatments that their health carriers must provide or pay for. Before the Act, if an insured had a medical condition that could not be effectively treated by traditional medicine (*e.g.*, lower back pain), but could be treated by alternative medicine (*e.g.*, by a chiropractor), the insured bore the risk that he would need this alternative medical treatment. Now, a substantial portion of Washington's population bears that risk because every health insurance policy must cover that alternative treatment. *Metropolitan Life*, 471 U.S. at 743.

It is irrelevant that the Act accomplishes its risk-spreading function in an unusual way. Risk-spreading is a

concept that involves more than the mere selection of certain medical conditions for coverage. The degree of risk-spreading between the insured and the carrier also depends on what kinds of treatments the policy agrees to pay for, what kinds of deductibles it will charge, and whether there will be a cap on overall expenses. *See Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir.1993) ("[T]reatment and cost are important components of health insurance.") A state law, for instance, that outlawed deductibles and co-payments would have a massive effect on risk-spreading, even though it did not alter the medical conditions covered by the policy. Similarly, a law such as the Act, that mandates expanded treatments for covered conditions also affects risk-spreading by shifting more risk to the insurer (*i.e.*, the risk that these treatments will be needed). Thus, despite the unusual form of the Act, it is emphatically a regulation of risk-spreading.

The plaintiffs focus too much on the phrasing of the Act in their effort to characterize it as affecting only the carrier-provider relationship, not the carrier-insured relationship. It is true that the Act says that every health plan must permit "every category of health provider to provide health services or care for conditions included in the basic health plan. . . . " RCW 48.43.045(1). But the key word is "category," not "provider." The statute does not require any carrier to contract or deal with any particular provider; it merely forbids a carrier from excluding a complete *type* of provider. By contrast, the Act does require *every* health plan to let *every* insured make use of alternative medical treatments. Although this requirement confers a residual benefit on providers as a class, its

primary benefit is to the insured. *See Stuart Circle*, 995 F.2d at 504 ("[A]lthough facially the statute only directly affects providers, it indirectly affects the insured's choice of provider and the consequent costs to the insured if he or she deems an excluded provider to be better qualified for treatment of a specific illness or accident. In this way it affects the risk that an insured must bear.")

Another way to see how the Act confers a benefit on insureds is to contrast it with the "any willing provider" statutes that some states have enacted. An "any willing provider" law requires a health carrier to allow an insured to see any doctor willing to abide by the terms of the insurance plan and willing to provide only those treatments specified in the plan. Such a statute does not expand the conditions covered by the policy, *nor* does it expand the types of treatments available under the policy. *E.g., Texas Pharmacy*, 105 F.3d at 1041; *CIGNA*, 82 F.3d at 644 n. 2. Some courts have taken the view that an "any willing provider" statute does not affect the risk borne by the insured, reasoning that it merely regulates the carrier-provider relationship. *Prudential Ins. Co. v. National Park Med. Ctr., Inc.*, 964 F.Supp. 1285, 1298 (E.D.Ark.1997); *Nielsen*, 917 F.Supp. at 1541; *Hayden*, 843 F.Supp. at 1435-36. Other courts have disagreed and held that an "any willing provider" statute does spread risk. *See Texas Pharmacy*, 105 F.3d at 1041; *Stuart Circle*, 995 F.2d at 503; *Blue Cross and Blue Shield v. Bell*, 798 F.2d 1331, 1334-35 (10th Cir.1986). Regardless of the view one takes of an "any willing provider" statute (and we express no opinion on that), the Act even more clearly affects the carrier-insured relationship. The Act works a substantive alteration of the insurance policy and mandates that the

insurer cover an expanded list of treatments. It therefore spreads the risk that an insured may need alternative medical treatments to heal his or her medical condition. Accordingly, the Act is within the common-sense definition of insurance. *Metropolitan Life*, 471 U.S. at 743.

2. The McCarran-Ferguson Test

The second prong of the savings clause test is whether the law meets the McCarran-Ferguson test for the business of insurance. *Cisneros*, 134 F.3d at 944-47. There are three factors in the McCarran-Ferguson test: First, does the law spread risk? Second, does the law regulate an integral part of the policy relationship between the carrier and the insured? Third, is the law limited to entities within the insurance industry? *Id.* at 945 (quoting *Metropolitan Life*, 471 U.S. at 743). In this circuit, "the McCarran-Ferguson factors are simply relevant considerations or guideposts, not separate essential elements of a three-part test that must each be satisfied for a law to escape preemption." *Id.* at 946.

We face no new arguments here. We have already discussed the first factor, risk spreading, under the "common-sense" understanding of insurance. As to the second – whether the Act regulates an integral part of the carrier-insured policy relationship – we again refer to the previous section of the opinion. Because the Act does spread risk and therefore does confer a benefit on insureds, it does regulate an integral part of the carrier-insured relationship. *Metropolitan Life*, 471 U.S. at 743.

The third prong – whether the Act is limited to entities within the insurance industry – once again takes

us back to whether the Act reaches some self-insured ERISA plans, which by definition are not within the insurance industry. 29 U.S.C. § 1144(b)(2)(B). As we have already stated, we think it does not.

Accordingly, the Act satisfies all three prongs of the McCarran-Ferguson test and falls within the savings clause as a regulation of insurance. The district court erred when it held to the contrary. *Washington Physicians Serv. Ass'n*, 967 F.Supp. 427-31.

III.

The district court's grant of summary judgment in favor of the plaintiffs is reversed, and the case is remanded with instructions to enter summary judgment for the defendants.

REVERSED and REMANDED.

APPENDIX B

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

WASHINGTON PHYSICIANS SERVICE ASSOCIATION, *et al.*, Plaintiffs, vs. CHRISTINE GREGOIRE, *et al.*, Defendants.	NO. C96-5850FDB ORDER ON DEFENDANTS' MOTION FOR RECONSIDERATION (Filed Jul. 23, 1997)

This matter comes before the court upon Defendants' Motion For Reconsideration And Clarification of Terms of Order of May 2, 1997. Plaintiffs oppose this motion with one exception.

The Court has considered the arguments of the parties in reviewing its May 2, 1997 order and is persuaded that reconsideration must be denied for the reasons stated in Plaintiffs' opposition. The Court also notes that Plaintiffs concede that RCW 48.43.045(2) is severable and may be enforced regardless of RCW 48.43.045(1) having been held by this Court to be preempted.

Accordingly, it is hereby

ORDERED:

(1) Defendants' Motion For Reconsideration and Clarification of Terms of Order of May 2, 1997 is DENIED, except that

(2) RCW 48.43.045(2) is severable and may be enforced by the Defendants.

DATED this 23 day of July, 1997.

/s/ Franklin D. Burgess
FRANKLIN D. BURGESS
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

WASHINGTON PHYSICIANS SERVICE ASSOCIATION; MEDICAL SERVICE CORPORATION OF EASTERN WASHINGTON, a Health Care Service Contractor; GOOD HEALTH PLAN OF WASHINGTON, a Health Maintenance Organization; PACIFICARE OF WASHINGTON, a Health Care Service Contractor; SELECTCARE HEALTH PLANS, a Health Maintenance Organization; QUALMED WASHINGTON HEALTH PLAN, INC., a Health Maintenance Organization; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, a Health Maintenance Organization; BLUE CROSS AND BLUE SHIELD OF OREGON, a Health Care Service Contractor; GROUP HEALTH COOPERATIVE OF PUGET SOUND, a Health Maintenance Organization; BLUE CROSS OF WASHINGTON AND ALASKA, a Health Care Service Contractor; PIERCE COUNTY MEDICAL BUREAU INC., a Health Care Service Contractor; and KING COUNTY MEDICAL BLUE SHIELD, a Health Care Service Contractor, Plaintiffs, vs.	NO. C96-5850FDB ORDER GRANTING PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT AND DENYING DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT (Filed May 2, 1997)

CHRISTINE O. GREGOIRE, in her capacity as Attorney General for the State of Washington; and DEBORAH SENN, in her capacity as Insurance Commissioner of the State of Washington,

Defendants.

INTRODUCTION

This matter comes before the Court on cross motions for summary judgment. Neither party argues that there exist material issues of fact requiring a trial.

Plaintiffs, a consortium of health care contractors and service providers, initiated the case by filing a complaint for declaratory and injunctive relief on September 19, 1996. Defendants are Christine Gregoire, as Attorney General, and Deborah Senn, in her capacity as Insurance Commissioner of the State of Washington.

At issue is whether the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 et seq., preempts RCW 48.43.045, the Alternative Provider Statute and the State's interpretation of the Statute (the Act), or whether ERISA's insurance savings clause, 29 U.S.C. § 1144(a), (b)(2)(A), allows the State to enforce its recently enacted law which mandates the use of all state-certified health care providers by health carriers. The ultimate question is whether the State can require plaintiffs to provide for their subscribers the services of licensed alternative health care providers, including the services of chiropractors, acupuncturists and other nontraditional providers.

This Court holds that the Act is preempted by ERISA, and that the Act does not fall within the exemption provided by ERISA'S "Savings Clause; RCW 48.43.045 is, therefore, not a valid exercise of the State's authority to regulate health service entities.

LEGAL BACKGROUND

ERISA Preemption

Congress enacted ERISA in order to establish basic uniform laws for employee benefit plans in specified areas. Earlier ERISA preemption cases held that in determining whether a federal statute preempts a state law, Congress' intent controls. *See FMC Corp. v. Holliday,* 498 U.S. 52, 56 111 S.Ct. 403, 407, 112 L.d. 356 (1990). "If the intent of Congress is clear, that is the end of the matter; for the court . . . must give effect to the unambiguously express intent of Congress." *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 87, 842-43, 104 S.Ct. 2778, 2781, 81 L.Ed.2d 694 (1984). Fearful of a patchwork of state and local regulatory requirements, Congress designed ERISA with a broad preemption provision at its core. *FMC Corp. v. Holliday,* 498 U.S. 56, 111 S.Ct. 407. Recently, however, the Supreme Court indicated that henceforward courts should decide whether ERISA preempts state law not by asking whether the language requires it or whether Congress intended it but by asking whether preemption makes sense as a matter of ERISA policy. *See New York State Conference of Blue Cross/Blue Shield Plans v. Travelers Insurance Co.,* 54 U.S. ___, 115 S.Ct. 1617, 131 L.Ed.2d 695 (1995).

The Insurance Savings Clause

Generally speaking, ERISA's preemption clause applies to all state laws that "relate to" employee welfare benefit plans governed by ERISA. However, not all regulations purporting to relate to employee welfare benefit plans are preempted. Congress carved out an exception, called the "savings clause," 29 U.S.C. § 1144(b)(2)(A), ERISA § 514(b)(2)(A), which exempts from preemption those laws that regulate insurance, banking or securities. This exception for insurance regulation is itself limited, however, by the provision that an employee welfare benefit plan may not "be deemed to be an insurance company or other insurer." *See* ERISA § 514(b)(2)(B), 29 U.S.C. § 1104(b)(2)(B).

RCW 48.43.045

In 1995, the Washington State legislature enacted a statute that directs health carriers to make available all categories of state-licensed health care providers to their subscribers. The statute, RCW 48.43.045, reads in part:

> Every health plan delivered, issued for delivery, or renewed by a health carrier on or after January 1, 1996, shall . . . [p]ermit every category of health care provider to provide health services or care for conditions included in the basic health plan services.

Both parties agree the Act requires health carriers (health maintenance organizations, health care services contractors, etc.) to reimburse providers (doctors, dentists, etc.) for all types of licensed care, including alternative care. The parties disagree as to the validity of the

Act. Plaintiffs contend that: 1) a health carrier's business is not in the nature of insurance and is, therefore, outside the realm of ERISA preemption; and 2) the Act is preempted under ERISA's so-called "relates to" doctrine. Defendants maintain that because the law acts to spread the risk from policyholder to health carrier and satisfies the tests for inclusion under the insurance savings clause, it is not preempted.

ANALYSIS

I. ERISA Preemption – "Relate To" Test

Defendants argue that the Act regulates matters traditionally within the police powers of the state to assure the health and safety of the people of the state. Also, the plan regulates only the insurer not the benefit plan and it does not bind administrators to any particular choice, particularly with areas requiring uniformity, eligibility of claimants, making disbursements, monitoring funds availability, and record keeping. Defendants' argument lacks the force and logic of that presented by Plaintiffs.

There is ERISA preemption if the state law attempts to regulate: (i) the structure, (ii) the content, (iii) the method of administration, or (iv) plan requirements that vary from state to state. *Travelers,* 115 S.Ct. at 1677-78. ERISA supersedes "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." *See* ERISA § 514(a), 29 U.S.C. § 1144(a). ERISA not only preempts state laws and regulations that are directed at employee benefit laws, but also those laws or regulations that have a "connection with" or a "reference to" such plans. *See Shaw v. Delta Air Lines, Inc.,* 463 U.S.

85, 96-97 (1983); and, *e.g., Alessi v. Raybestos, Manhattan, Inc.*, 451 U.S. 504, 525 (1981).

The Act "relates to" benefit plans in several ways. The Act "relates to" the administration of employee benefit plans because it interferes with the plan administrators' discretion of whom to contract with and whom to pay. The Act "relates to" the structure of employee benefit plans because it prohibits ERISA plans from selecting an arrangement that does not cover every category of provider. *See, e.g., Blue Cross and Blue Shield of Alabama v. Peacock's Apothecary, Inc.*, 567 F. Supp. 1258, 1276 (N.D. Ala. 1983) (interference with the structure of contractual relationships with participating pharmacies "relates to" plans). The Act "relates to" content because a health plan is required to cover provider services that it did not cover previously. *Accord Cigna Healthplan of Louisiana, Inc. v. State of Louisiana*, 82 F.3d 642, 648 (5th Cir. 1996) ("any willing provider" statute "relates to" ERISA); *Stuart Circle Hospital Corp. v. Aetna Health Management*, 995 F.2d 500, 502 (4th Cir. 1993) (statute that restricts the ability of an insurance company to limit choice of providers "relates to" an employee benefit plan); *Blue Cross and Blue Shield of Alabama v. Nielsen*, 917 F. Supp. 1532, 1536-37 (N.D. Ala. 1996) (statute requiring coverage of any licensed dentist and prohibiting payor's review of quality or utilization "related to" employee benefit plan).

There is also the risk of conflicting and inconsistent state and local regulation, as, for example, an Oregon employer who contracts with a health carrier in Washington to cover employees in Washington would have to comply with the Act even if there were no such mandate for the employer in Oregon.

The "relate to" test of ERISA preemption has been satisfied, and the State Alternative Provider Mandate Statute and State Interpretations are preempted unless saved from preemption as a law "regulating insurance."

II. ERISA Preemption – The Savings Clause

In determining whether the Act comes within the Savings Clause as regulating insurance, a two-step analysis is employed as set forth in *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985). The first step is a "common sense" view analyzing whether the law at issue is specifically directed at the insurance industry, and thus, logically falls within the scope of the "regulates insurance' language of the Savings Clause. Next, a court must analyze whether the law regulates the "business of insurance" as described by the McCarran-Ferguson Act. A state law must be treated as regulating insurance under both the "common sense view" and all three parts of the McCarran-Ferguson analysis in order to be saved from preemption. *Cigna Healthplan of Louisiana, Inc. v. State of Louisiana*, 82 F.3d 642 (5th Cir. 1996); *Anschultz v. Connecticut General Life Insurance Company*, 850 F.2d 1467, 1468 (11th Cir. 1988).

A. The Common Sense View

Defendants argue that the Act here regulates the terms of insurance by mandating providers within service categories. In order to regulate insurance," however, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry. *Pilot Life v. Dedeaux*, 481 U.S. 41, 45 (1987). The

Alternative Provider Mandate Statute is directed at "Health Carriers" and "Health Plans," each of which is qualitatively different and substantially broader than the insurance industry. The Act is not limited to policies, contracts, or agreements to "indemnify" or "pay" for health services as would be the case in insurance products, but also extends to contracts or arrangements which merely "provide" or "arrange" for health care service.

The exclusion of "employer-sponsored self-funded Health Plans" from the Act's definition of "Health Plan" does not operate to avoid ERISA preemption. There are other plans that the Act would regulate: certain ERISA plans that may not be regulated by virtue of the "deemer clause," 29 U.S.C. § 1144(b)(2)(B), and governmental or church plans administered by a health carrier, which may not be ERISA plans, but which are clearly outside the insurance industry. The Act, is directed at "Health Carriers," which are defined in RCW 48.43.005(8) as "a disability insurer regulated under Chapter 48.20 or 48.21 RCW, a health service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020." Thus, on its face, the Alternative Provider Mandate Statute is not directed simply at insurers, but also at HMOs. HMOs are not insurers, as Insurance is defined as "a contract by which one party, for a consideration . . . promises to make a certain payment of money upon the destruction or injury of something in which the other party has an interest." *Couch on Insurance, 2d,* § 1:2 (1984). RCW 48.01.040 defines "insurance" as "a contract whereby one undertakes to indemnify another or pay a specified amount upon determinable contingencies." An HMO is not an insurer but a

"health care delivery system"; the purpose of an HMO is described in the HMO Act:

> The Legislature declares that the establishment of qualified prepaid group and individual practice health care delivery systems should be encouraged in order to provide all citizens of the state with the freedom of choice between competitive, alternative health care delivery systems necessary to realize their right to health.

RCW 48.46.010. While insurers indemnify health care, HMOs provide health care services. HMOs' activities in providing health care services are not subject to insurance laws:

> Any health maintenance organization may enter into agreements with or for the benefit of persons or groups of persons which require prepayment for health care services by or for such persons in consideration of the health maintenance organization *providing health care services* to such persons. *Such activity is not subject to the laws relating to insurance if the health care services are rendered directly by the health maintenance organizations or by any provider which has a contract or other arrangement with the health maintenance organization to render health services to enrolled participants.*

RCW 48.46.060(1) (emphasis added).

The above discussion reveals that the Act is not specifically directed at the insurance industry and thus fails the "common Sense" view of the term "regulates insurance." This alone would be enough to remove the Act and its interpretations from Savings Clause protection leaving them preempted by ERISA Section 514, 29 U.S.C. § 1144.

But assuming, *arguendo*, that the Act passes the "common sense" test, the McCarran-Ferguson "business of insurance" test must be satisfied.

B. The McCarran-Ferguson Criteria

The McCarran-Ferguson "business of insurance" test provides three criteria for determining whether a statute "regulates insurance." These factors are set forth in *Pilot Life*, 41 U.S. at 48-49 as follows:

> (F)irst whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited solely to entities within the insurance industry.

1. The Act and State Interpretations Do Not Spread Risk

The Act and State Interpretations do not mandate the coverage of any additional conditions by any affected plan or contract. "The risk spreading principle concerns the nature of the coverage of the policy – in other words, the risks of injury that the insurance company will bear for the insured." *Smith v. Jefferson Pilot Life Insurance Co.*, 14 F.3d 562, 569 (11th Cir. 1994), *cert. denied*, 115 S.Ct. 57 (1994). The contract between the carrier and the subscriber enumerates what conditions will be covered by the plan. For a subscriber with a covered condition, the shifting of risk occurs at the time such contract is entered into – the condition is either covered or not covered. On

the other hand, the arrangements that a carrier makes with a particular category of provider does not shift the risk between the carrier and the subscriber any more than a decision to include or exclude a particular Dr. Smith or Dr. Jones in a preferred panel shifts the risk. In *Group Life and Health Insurance Company v. Royal Drug Co.*, 440 U.S. 205 (1979), the issue was whether contracts between the insurer and participating pharmacies constituted the business of insurance such that the contracts were exempted from federal antitrust scrutiny. The court, applying the three criteria in the McCarran-Ferguson "business of insurance" test, concluded that the pharmacy agreements were "merely arrangements for the purchase of goods and services" by the "insurer," and thus, outside the scope of the "business of insurance." *Id.* at 214. As in the *Royal Drug* case, the Act does not affect the allocation of risk or cost as between the insurer and the insured, but rather, imposes restrictions on the freedom of the carrier to purchase provider services. Moreover, in those situations where a health carrier merely performs administrative functions for self-funded union plans or self-funded plans of trade associations or other groups, there can be no risk shifting.

Defendants argue that there is risk shifting because the entities covered by the Act bear the risk that an insured, a policyholder, will secure treatment from alternative providers and be reimbursed rather than having to pay for it as before. Defendants rely on *Blue Cross and Blue Shield of Alabama v. Bell*, 798 F.2d 1331 (10th Cir. 1986). That case is not compelling, however, and has been criticized. In *Blue Cross and Blue Shield of Alabama v.*

Nielsen, 917 F. Supp. 1532, 1542 (N.D. Ala. 1996), the Court stated:

> In discussing the mandated provider section of the statute, the *Bell* court's analysis turned on its characterization of this potion of the statute as a "freedom of choice" law. The court concluded, without citing any authority or meaningful discussion, that the mandated provider statute met the first McCarran-Ferguson criterion – risk spreading – because "[i]mplicit in the [scope of] coverage . . . is the insured's choice of a deliverer of the care." *Bell*, 798 F.2d at 1335.

Nielsen presents a cogent analysis of the difference between mandatory provider laws and mandated benefits laws:

> There is however, a principled difference between mandated benefits laws and mandated provider laws. The Acts directly benefit those providers who avail themselves of the rights afforded by the Acts. The relationship between the provider and the patient is separate from the relationship with the provider and the payor. The Acts affect who gets paid, and that determination certainly has an effect, albeit an incidental one, on the subscriber. The Acts are not an integral part of the contractual relationship between Blue Cross and the patient/subscriber since the Acts do not affect the substantive coverage terms of the contracts defining the subscriber/payor relationship.

Nielsen, 917 F. Supp. at 1541-42. The *Nielsen* Court concluded:

> Under the first McCarran-Ferguson criterion, *the choice of a health care provider has nothing to do*

> *with spreading the risk of coverage.* As explained by the Eleventh Circuit in *Jefferson Pilot*, spreading the risk entails "the risks of injury that the insurance company will bear for the insured." *Jefferson Pilot*, 14 F.3d at 569 (citation omitted). Taking the court's example in *Bell*, coverage for a back injury, *spreading the risk entails the amount of coverage that the insurer will bear for treatment of a particular injury or procedure – not who will perform the treatment.*

Id. at 1542 (emphasis added).

More important, the Ninth Circuit has addressed the issue. In *Hahn v. Oregon Physicians Service*, 689 F.2d 840, 843 (9th Cir. 1982) the Court relied on *Royal Drug* and held it was not established "that there are any *bona fide* risk-related reasons for an insurer to distinguish between the services of M.D.'s and podiatrists, much less that such a distinction is at the core of what is commonly understood to be the "business of insurance."

The more compelling argument is that the Act herein does not shift risk and that the First element of the McCarran-Ferguson criteria is not satisfied.

2. The Act Is Not Integral To The Insurer/Insured Relationship

The Act relates to the terms of the relationship between the carrier and the providers, not the relationship between the carrier and its subscribers. Defendants argue that the Act affects the benefits that policyholders may enjoy. While there may be an indirect effect, this is insufficient to satisfy this element – it must be integral, and a contract between a carrier and a provider is not

integral to carrier/subscriber relationship. Stated differently, an insured's right to coverage of a certain condition is integral to the insurer/insured relationship as it involves the risk that the insurer bears for the insured. The Act, however, affects the administrative function of who gets paid and under what terms must they render services; these are issues of how the plan chooses to provide care for a condition for which coverage has been promised. *See Nielsen*, 917 F. Supp. 1532 (1996), and *Hahn*, 689 F.2d at 843.

3. The Act is Not Directed Solely At The Insurance Industry

It is not enough that the Act is directed at the insurance industry and possible other parties; it must be directed *soley* at the insurance industry. Because the Act reaches beyond insurers to include HMOs and others, the Act fails this element of the McCarran-Ferguson test.

While the status of an HMO is a gray area because it possesses certain characteristics of insurance and health care, it appears that its primary mission is health care as opposed to insurance. As earlier discussed, HMOs are not "insurers" under the Revised Code of Washington, nor are they subject to insurance laws where the HMO renders the health care services or providers under contract to the HMO render the services. While there are clearly some aspects of health care financing by HMOs, it seems more logical to conclude that these entities are primarily involved in the health care industry, not the insurance industry. Furthermore, because the definitions of "Health Plans" includes uninsured ERISA plans such as self-

funded Taft-Hartley plans and multiple employer plans sponsored, for example, by trade associations, the Act obviously extends beyond the insurance industry to uninsured plans. These plans may not be directly or indirectly regulated by the state. *Metropolitan Life Insurance Company v. Massachusetts*, 471 U.S. 724 (1985); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990).

The Act extends to entities beyond the insurance industry and, therefore, clearly fails the third McCarran-Ferguson criterion.

CONCLUSION

The Act "relates to" ERISA plans because the law regulates the structure, the content, the method of administration, and the uniform requirements of employee benefit plans. The Act is not saved from preemption because it fails to pass each of the requirements of the "savings" clause: it fails the common sense test because it is not directed solely at the insurance industry but at health carriers and health plans; it does not transfer risk, but governs the purchase of goods and services; it is not an integral part of the relationship between insurer and insured, but governs relationships with providers; and it is not limited to entities within the insurance industry.

The Alternative Provider Mandate Statute and State Interpretations are, therefore, preempted.

Accordingly, and concluding that oral argument is unnecessary, it is hereby

ORDERED:

(1) Plaintiffs' Motion for Summary Judgment is GRANTED, and Defendants and their agents and employees are enjoined from enforcing the Statute and State Interpretations;

(2) Defendant's Motion for Summary Judgment is DENIED;

(3) The parties' respective motions to file over-length briefs are GRANTED;

(4) The parties' respective motions to strike and MOOT, as neither of the subject material were of significance to the analysis and decision herein.

DATED this 2 day of May, 1997.

/s/ Franklin D. Burgess
FRANKLIN D. BURGESS
UNITED STATES
DISTRICT JUDGE

BEFORE THE INSURANCE COMMISSIONER

OF THE STATE OF WASHINGTON

In re Petition of: Blue Cross of Washington and Alaska, King County Medical Blue Shield, Pierce County Medical Bureau, Group Health Cooperative of Puget Sound, Blue Cross and Blue Shield of Oregon, Washington Physician Service Association, Medical Service Corporation of Eastern Washington, Kaiser Foundation Health Plan of the Northwest, Qual Med Washington Health Plan, Selectcare Health Plans, Pacific Care of Washington, and Good Health Plan of Washington.

No. G 96-13

DECLARATORY ORDER

RE: RCW 48.43.045

Introduction

This matter came before the Office of the Insurance Commissioner ("OIC") pursuant to a Petition for Declaratory Order filed on May 21, 1996 by eleven health carriers and a trade association (collectively "petitioners"). The address of petitioners' counsel is:

Carney, Badley, Smith & Spellman

Palmer Robinson

2200 Columbia Center

701 Fifth Avenue

Seattle, WA 98104-7091

Statutes at Issue

As authorized by RCW 34.05.240, petitioners requested that the OIC interpret RCW 48.43.045, a new section of the insurance code which provides, in relevant part, as follows:

Every health plan delivered, issued for delivery, or renewed by a health carrier on or after January 1, 1996, shall:

(1) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that:

(a) The provision of such services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services.

Procedural History

In the months preceding the January 1996 implementation date of the new law, the OIC received numerous inquiries and other correspondence from carriers and health care providers seeking information on how the new statute would be interpreted. (1) In response to these inquiries, Commissioner Senn issued a bulletin to all health carriers in the state, explaining the statutory

requirements and responding to some of the specific questions which had been raised. AR 683-684.

A group of health carriers (including most of the petitioners in this proceeding) responded to the bulletin by filing a Complaint for Declaratory Judgment, *Blue Cross v. Senn*, Thurston County Superior Court Cause No. 96-2-00137-3. *See* AR 1005-1009. The court disposed of the primary issue in that case on summary judgment, holding that plaintiffs had failed to exhaust their administrative remedies and should submit their concerns to the OIC prior to seeking judicial review. AR 1264-1267.

The OIC received the Petition for Declaratory Order on May 21, 1996 and notified all interested parties of their opportunity to submit written comments or briefs as provided in RCW 34.05.240. AR 1435-1546. The comment period extended from May 30 to July 15, 1996. *Id.* Petitioners resubmitted their motion for summary judgment filed in the superior court litigation. AR 1032-1054. Comments were also received from a variety of consumers and health care providers. AR 1547-1587. Copies of all comments received have been provided to petitioners.

In addition, the OIC has received and reviewed various of petitioners' contracts which are subject to the new statutory requirements.(2) Many of these reflect petitioners' litigation posture, which is that they need not comply with the OIC's interpretation of 48.43.045 because it is incorrect.(3) The OIC has also received a number of written complaints from consumers and providers who are frustrated with the manner in which petitioners are interpreting the law. AR 557-677. Over one hundred persons attended a recent investigatory hearing in Seattle on

May 6, 1996, and many testified regarding the hardships which they are experiencing due to uncertainties regarding the statutory requirements. AR 1268-1338.(4)

The petition, comments, testimony, and complaints received thus far present actual uncertainties and controversies, so that this declaratory order is not merely an advisory opinion. *See* RCW 34.05.240(b). The issuance of the order requested is not likely to result in any adverse effect on any person (other than, possibly, petitioners who requested it), and any such adverse effect would be outweighed by the benefit to be gained by clarifying the statutory requirements as requested. *See* RCW 34.05.240(d). Thus, the statutory conditions for issuance of this declaratory order have been satisfied.

Administrative Record

The record for this declaratory order has been compiled and indexed separately. It is cited herein in the form "AR ___."

Overview of regulatory structure

1. Definitions.

The delivery and financing of health care in this state is governed, in relevant part, by Title 48 Insurance of the Revised Code of Washington. There are four components of the regulatory structure. First, there are the entities which finance health care. Some of these are insurance companies; others are health care service contractors or health maintenance organizations ("HMOs"). The code

includes all such entities in its definition of "health carrier" or "carrier." RCW 48.43.005(8). Thus, the eleven health care service contractors and HMOs listed as petitioners in this action, *see* AR 1418, are "carriers." Carriers develop and market "health plans" or "health benefit plans." These plans are in the form of policies, contracts, or agreements to provide for health care services. RCW 48.43.005(9). "Health care service" means the service offered by health care providers relating to the prevention, cure, or treatment of illness, injury or disease. RCW 48.43.005(7).

"Health care providers" are the second component of the regulatory structure. A "provider" is a person who is licensed to practice health or health-related services according to the licensing requirements for their respective fields set forth in Title 18 or Chapter 70.127 RCW. *See* RCW 48.43.005(6).

The third component of the regulatory structure is the OIC, which maintains a record of all health care contracts offered for sale(5) and may disapprove any which contain ambiguities, inconsistencies, deceptive advertising, unreasonable benefits in relation to cost, unreasonable treatment restrictions, violations of Title 48, violations of OIC regulations, or violations of law.(6)

The fourth component of health insurance regulation is the purchasing and consuming public, whose protection is the responsibility of the OIC. *See* RCW 48.30.010 and RCW 48.30A.

2. 1993 Health Care Reform Legislation.

In 1993, the Legislature made sweeping changes to the content, availability and delivery of health insurance. *See* 1993 Wash. Laws Ch. 492 (formerly codified in scattered sections (many repealed 1995) of Titles 43 and 48 RCW).(7) This new legislation mandated that health plans contain a minimum "Uniform Benefits Package" and be "certified" by the OIC. RCW 43.72.090 (repealed 1995). The Uniform Benefits Package was designed to emphasize "proven preventative and primary health care." "Essential services," which were to be included in every plan, included primary and specialty health services, inpatient and outpatient hospital services, prescription drugs and medications, reproductive services, maternity and well-child care, preventive dental services for children, case-managed chemical dependency, mental health, short-term skilled nursing facility, home health and hospice services. RCW 43.72.130(2) (repealed 1995). Uniform benefits packages were to be available by July 1, 1995. RCW 43.72.090 (repealed 1995).

Additionally, every certified health plan was required to:

(14) Permit every category of health care provider to provide health services or care for conditions included in the **uniform benefits package** to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practices; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services.

RCW 43.72.100 (repealed 1995) (emphasis added). The 1993 legislation also required that:

All licensed health care providers . . . irrespective of the type or kind of practice, should be afforded the opportunity for inclusion in certified health plans consistent with the goal of health care reform.

RCW 48.43.170(2) (repealed 1995).

3. 1995 Legislation.

In 1995, the Legislature almost totally reversed the 1993 legislative trend toward uniform managed health care. 1995 Wash. Laws Chap. 265, section 27. It also abolished the Uniform Benefits Package. *Id.* at section 27(16). One of the only "holdover" pieces of the 1993 legislation is the inclusion in RCW 48.43.045 of former RCW 43.72.100(14). However, instead of the Uniform Benefits Package as the benchmark health care plan, the 1995 version of the law requires that every provider be permitted to provide health care services or care for conditions included in the **Basic Health Plan**.(8) RCW 48.43.045.

Overview of Questions presented

The controversy surrounding the interpretation of RCW 48.43.045 concerns the following five questions:

1. *Extent of Statutory Requirement.* What medical treatments does the statute cover? Must carriers permit all

categories of providers to treat *all* conditions within the scope of their license? What is the effect of the exclusion of a specific treatment from the Basic Health Plan ("BHP"), if the BHP nonetheless covers a condition for which that treatment is appropriate?

2. *Plans Covered.* Do the requirements of RCW 48.43.045 apply to all plans? Or are they limited to a particular type of plans, [sic] such as those mandated by RCW 48.44.022, RCW 48.44.023, RCW 48.46.064 and RCW 48.46.066 ("BHP look-alikes" or "Model Plans")? Alternatively, are the Model Plans exempted from the requirements of RCW 48.43.045, on the ground that they must be "identical" to the BHP?

3. *"Cost-effective and Clinically Efficacious" Services.* What is the meaning of the statutory requirement that providers agree to abide by standards related to the provision of cost-effective and clinically efficacious services? Does this authorize a carrier to exclude an entire category of providers if it believes that their services are not cost-effective or clinically efficacious?

4. *Limitations on Services.* Under what circumstances, if any, may a carrier limit the services which a policyholder may obtain from a specific category of providers? For example, may the policy expressly limit the number of visits to be covered, or contain an annual cost limitation, for a specific type of providers [sic] or group of providers?

5. *Optional Benefits.* May a carrier comply with RCW 48.43.045 by offering the services of certain categories of providers as a separately priced optional benefit?

Analysis

Introduction

a. Origins of Statute.

As discussed previously, RCW 48.43.045 originated as part of the Washington Health Services Act of 1993. *See* 1993 Wash. Laws Ch. 492, section 428, formerly codified at RCW 43.72.100(14) (repealed 1995), AR 74-76.(9) One purpose of the 1993 Act was to increase consumers' access to different kinds of providers by protecting those providers against being unfairly excluded from health carriers' networks.(10) In order to accomplish this, the statute needed to address four questions: (1) Which health care providers would be protected; (2) What medical conditions could those providers treat; (3) What treatments could they use; and (4) What health plans would include the new protections?

With respect to the first of these questions – which providers – the statute took a broad approach: "Every" category of health care provider was covered, limited only by the requirement that those providers be licensed under Title 18 or chapter 70.127 RCW. The 1993 law stated:

A certified health plan [i.e., every health carrier(11)] shall: . . . (14) Permit every category of health care provider to provide health services or care for conditions included in the uniform benefits package to the extent that:

(a) The provision of such services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services.

RCW 43.72.100 (repealed 1995); *see also* RCW 43.72.010(12) (repealed 1995) (defining term "health care provider" as persons licensed under Title 18 or chapter 70.127 RCW).

With respect to the second question – what medical conditions – the statute referred to those covered by the Uniform Benefits Package ("UBP").(12) Third, the statute chose the broadest possible approach in defining what treatments would be provided, requiring only that they be "within the health care providers' permitted scope of practice." To the extent that treatments ("services or care") came within the providers' scope of practice, every category of provider could provide those treatments for any condition covered by the UBP. And finally, the statute applied to all certified health plans, that is, all health carriers. *See* note 11, *supra*.

b. 1995 Legislative Session.

As discussed previously, the 1995 Washington Legislature repealed many of the aspects of health care reforms which had been adopted in 1993. Among other changes, the concept of uniformity in health care was abandoned, and the UBP was abolished. 1995 Wash. Laws Chap 265, section 27(16). This had a number of ripple effects. One was the effect on the "every category of provider" statute

at issue herein. That statute had previously used the UBP in its definition of what medical conditions were covered by the statute, that is, all conditions covered by the UBP were to be treated by all categories of providers licensed to treat them. The loss of the UBP made it necessary to find an alternative way to answer the question of what medical conditions providers would be treating.

The legislature responded to this by substituting the Basic Health Plan ("BHP") for the UBP in the "every category" statute. The BHP is a health plan for low-income people. It is administered and partially funded by a state agency, the Health Care Authority ("HCA"), which publishes a "schedule of covered basic health care services" describing the coverage provided. RCW 70.47.060(1).(13)

Had the legislature wished to change the scope of the statute to a list of specific services (such as those services covered by the BHP), 1995 would have been the logical time to make such a change. This was not done. The only other change made in 1995 was the decision to move the statute out of Title 43 and into the Insurance Code, Title 48. Despite the close scrutiny to which all of the 1993 reforms were subjected, the "every category" statute survived the 1995 session virtually intact.

Question #1. Scope of Statutory Requirement.

a. Conditions Covered by the BHP.

Turning now to the specific questions presented by this petition, the first one concerns statutory scope: What medical treatments must be covered? One view (petitioners') is that the "every category" requirement does

not apply to any treatment, such as acupuncture, which is excluded from the BHP Schedule of Services. AR 1041-42. Health care providers, on the other hand, argue that the statutory requirement applies whenever the BHP covers the medical condition for which treatment is being rendered. AR 1569-76. This Order concludes that the scope of the statute must be measured by reference to a universe of medical *conditions* – specifically those conditions covered by the BHP – not by reference to the BHP's current list of traditional treatments for those conditions. To paraphrase, RCW 48.43.045(1)(a) requires that:

To the extent that services or care (i.e., treatments) are within the providers' scope of practice, every category of provider can provide those treatments for conditions covered by the BHP.

This conclusion follows from the words and grammar actually used in the statute.(14) Although RCW 48.43.045 is susceptible to other interpretations (such as petitioners'), it is clear that the operative words of the statute are *provide* and *conditions*. The phrase "health services or care" merely refers to the treatments which providers provide. As used in context, the phrase is essentially synonymous with the words "treatments," "medical care," "therapy," or even "healing." It doesn't really matter which word is used – the important thing is that providers take care of the problems from which their patients are suffering.

An analogy may be helpful here. It is as if June Cleaver (the Legislature) needed a bottle of milk for dinner. She says: "Beaver, please walk or run to the store and get

some milk." From the context, it is clear that the operative words are "get milk" – Mrs. Cleaver doesn't really care how Beaver transports himself to the store. Beaver responds that he would rather "take a walk." Mrs. Cleaver patiently reiterates: "When you go to the store, please be sure to get the milk," making her expectation even clearer. Similarly, under RCW 48.43.045, providers are to treat conditions – it doesn't matter what method they use.

Brackets and underlining have been inserted in the following passage from the statute to illustrate that "health services or care" (in brackets) refers to nothing more than how conditions are treated.(15) The operative words, *provide* and *conditions*, are underlined:

Every health plan delivered, issued for delivery, or renewed by a health carrier on or after January 1, 1996, shall:

(1) Permit every category of health care provider to *provide* [health services or care] for *conditions* included in the basic health plan services . . . [.]

And, lest there be any risk of ambiguity, the statute (like Mrs. Cleaver) reiterates its command. The next subsection says:

(a) The *provision* of such [services or care] is within the health care providers' permitted scope of practice . . . [.]

RCW 48.43.045(1)(a). Here, the operative word is *provision* – a form of the verb provide which was used in the prior subsection. This repetition underscores that the essence of the statutory mandate is carriers permitting providers to care for a defined set of medical conditions.

Petitioners' alternative interpretation of the statute, AR 1041-43, suffers from several weaknesses. First, the statute simply does not contain the exception that they want – nowhere does it authorize the exclusion of a medical service on the basis that it is not enumerated in the BHP schedule of services. The only way to find such an exception would be to read the statute as if it contained two different statements of its mandate, separated by the word "or." These two phrases may be located by reference to the brackets which have been placed in the following passage:

> Every health plan delivered, issued for delivery, or renewed by a health carrier on or after January 1, 1996, shall:
>
> (1) Permit every category of health care provider to [provide health services] or [care for conditions] included in the basic health plan services . . . [.]

RCW 48.43.045 (brackets added). Furthermore, the phrase "care for conditions" would need to disappear. Only then would it become possible to read the statute the way petitioners' want, as if it said that they only needed to "provide [the] health services . . . included in the [BHP]."

When the text is tortured in this way, it suffers from numerous violations of basic principles of statutory construction. First, by ignoring the phrase "care for conditions," it violates the rule that statutes should be construed so that all parts have meaning and none is rendered superfluous.(16) Moreover, it creates a grammatical ambiguity: Does the phrase "included in the [BHP]" modify the phrase "provide health services" *and* the phrase "care for conditions"? Or does it only modify

the immediately prior phrase "care for conditions"? Courts use a principle of statutory construction – the rule of prior antecedents – to resolve ambiguities such as this. The rule provides that "a qualifying or conditioning phrase [i.e. "included in the BHP"] . . . relates only to the last antecedent [i.e., "care for conditions] . . . [.]" *In re Renton*, 79 Wn.2d 374, 376-77 (1971).(17) Thus, even under petitioners' torturous reading, standard principles of statutory construction require the conclusion that the legislative focus was on the *conditions* covered by the BHP, not on the "health services" included in the BHP.(18)

The two words "health services" do not have to be read – as petitioners read them – as though they were a defined term of art. They are not defined in the statute. In fact, the drafters of the statute *declined* to use the one defined phrase which might have worked in this context. "Health care service" is defined in RCW 48.43.005(7).(19) Yet instead of using this defined term, the drafters chose an undefined one: "health services or care." When different terms are used in the same connection in different parts of a statute, it is presumed that a different meaning was intended.(20) Thus, undue importance cannot be placed on the two words: "health services." Those words simply stand for some of the things that health care providers provide. The legislature could equally well have substituted "care," "treatments," "therapy," or "healing."

Petitioners' reliance on the 1995 legislative session is also misplaced. *See* AR 1042-43. In fact, 1995 was a turning point for health care reform. The health care reforms of 1993 were all repealed or pared back substantially. Moreover, the "every category of provider" statute was itself revised and moved from Title 43 to Title 48 RCW. Had the

legislature wished to narrow the scope of the statute to those *services* covered by the BHP, 1995 would have been the logical time to make such a change. Yet despite the prevailing mood of cutbacks and retrenchment, this one section of the law was reenacted with its basic structure intact. 1995 Wash. Laws Ch. 265, section 8. The statute continued to define the extent of its requirement in terms of medical conditions – currently those conditions covered by the BHP(21) – rather than in terms of specific treatments for those conditions.

b. Petitioners' Concerns.

Petitioners have expressed the concern that the reference to conditions included in the BHP does not provide sufficient limitation on the scope of the statutory mandate, because so many conditions are covered.(22) Yet in fact, the BHP does *not* cover all medical conditions. For example, it excludes dental conditions, vision, non-emergency conditions treated in an emergency setting, infertility, speech impediments, obesity, and conditions resulting from acts of war. AR 1603-1605. A carrier which chooses to cover these conditions may legally exclude specific providers from treating those conditions. For example, the BHP does not cover the condition of infertility. Therefore, a carrier may limit its coverage of this condition to particular providers (such as M.D.s) while excluding other providers (such as naturopaths).

On the other hand, the BHP does cover the condition of pregnancy. A carrier may choose to exclude pregnancy from coverage altogether.(23) But, if pregnancy is covered, then the carrier must allow its policyholders to

choose the type of provider from whom they will obtain care for that condition. RCW 48.43.045 mandates that policyholders be given this choice, regardless of whether BHP enrollees enjoy the same option.

Petitioners' second concern is that defining the scope of RCW 48.43.045 in terms of conditions covered by the BHP could potentially "turn RCW 48.43.045 into a mandated benefits statute." That is, such an interpretation might conclude that carriers could never exclude any services designed to treat conditions covered by the BHP. For example, a nursing home might argue that the statute requires carriers to provide the service of long-term custodial care to persons suffering from Alzheimer's disease, on the grounds that the BHP does provide some limited coverage for that condition.

This second concern is well-founded. Given the language of the statute, such a result is certainly *possible*. But, given the consequences of including virtually all services, it is not likely that the Legislature intended this result.(24) Rather than mandating all services, the Legislature had a more modest goal: expanding consumers' health care choices by reducing perceived discrimination against nontraditional health care providers and the services they render for conditions covered by the BHP. The OIC's challenge, as an administrative agency, is to achieve that goal while minimizing unintended disruptions to the existing fabric of health insurance coverage.

Thus, carriers may exclude specific services – even if those services are used to treat conditions covered by the BHP – *unless* excluding the service would have the effect

of substantially excluding the services of an entire category of health care providers.(25) This conclusion balances the legislative intent to expand consumer choice with the carriers' ability to exclude services.

FINDING #1: RCW 48.43.045(1)(a) requires that petitioners cover all services or care (i.e., treatments) rendered by licensed providers, acting within their scope of practice, for conditions covered by the BHP. A carrier may exclude a particular service unless, by so doing, it substantially excludes an entire category of providers.

QUESTION #2: "Every Health Plan" and the Model Plans.

RCW 48.32.045 applies, on its face, to "every health plan" sold in Washington. Petitioners have suggested that the statute applies only to those plans mandated by RCW 48.44.022, RCW 48.44.023, RCW 48.46.064 and RCW 48.46.066 ("BHP look-alikes" or "Model Plans"). Such a limitation would be inconsistent with the plain words of the statute and is therefore rejected.(26)

a. "Identical" Benefits.

Petitioners have advanced another reason for restricting the scope of RCW 48.43.045 to something less than "every" health plan. Their analysis focuses on the tension between applying RCW 48.43.045 to "every health plan" on the one hand, and on the other hand, requiring that carriers market Model Plans which provide benefits "identical" to the schedule of services covered by the BHP. *See* AR 1041-43; and RCW 48.20.028, 48.21.045, 48.44.022, and 48.46.064. Their concern is that the BHP

excludes certain services (i.e., acupuncture) which carriers must cover in their own plans. How can a carrier's Model Plan be "identical" to the BHP if it covers something that would be excluded by the BHP?

Petitioners argue that this tension makes it "impossible" for a Model Plan to comply with the law. AR 1041-43. And furthermore, because that one plan cannot comply, then no plans should be required to do so. *Id.* This conclusion does not follow. Compliance is not "impossible;" the conflicting mandates can be reconciled by recognizing that the specific restrictions imposed on the Model Plans make them an exception to the general requirement contained in RCW 48.43.045. Established principles of statutory interpretation support such an approach; whenever two statutes are in apparent conflict, the more specific one governs.(27) Thus, a Model Plan may (and indeed, must) exclude any service that is excluded by the BHP.

b. "More or Less Comprehensive Benefits"

Petitioners have also argued that the requirement that they cover all categories of providers – even when those providers perform services excluded by the BHP – conflicts with their right to sell "other health benefit plans that may have more or less comprehensive *benefits* than the basic health plan . . . [.]" *See* RCW 48.20.028(1)(a); 48.21.045(1)(a); 48.44.022(1)(a); 48.46.066(1)(a) (emphasis added); AR 1041-43. This argument misconstrues the statutory use of the word "benefits." A benefit is not a provider. The statutes on which petitioners rely do not authorize the exclusion of any category of providers.

Rather, they authorize petitioners to issue policies which exclude certain conditions which are covered by the BHP.

For example, carriers may continue to market products which exclude pregnancy, even though pregnancy is covered by the BHP. *Id.* But, if a health plan does cover pregnancy, back pain, or any other condition covered by the BHP, then every category of provider must be allowed to treat it.

FINDING #2: All health plans, except the Model Plans (i.e., BHP look-alikes) must comply with RCW 48.43.045.

QUESTION #3. "Cost-effective and Clinically Efficacious Services."

RCW 48.43.045(1)(b) allows carriers to require that:

The providers agree to abide by standards related to: (i) Provision, utilization review, and cost containment of health services; (ii) Management and administrative procedures; and (iii) Provision of cost-effective and clinically efficacious health services.

a. Question Presented: Exclusion of Categories of Providers.

Petitioners have asked whether subsection (1)(b)(iii) can be applied in such a way that an entire *category* of providers is excluded from coverage on the basis of a carrier's determination that the providers' services are not cost effective or clinically efficacious. For the reasons given below, the answer is "no."

First, as a matter of statutory construction, the exclusion of an entire category of providers would render the statute itself meaningless. How could "the providers" possibly "agree" to abide by the carrier's standards, if there were no providers to do the agreeing? And why would any provider agree to standards which excluded the entire category to which that provider belonged? "In interpreting a statute, we must presume that the Legislature does not engage in meaningless acts."(28) In order for the language to make sense, it must be interpreted consistently with the familiar concept that carriers already have "standards" which govern the *manner* in which services are rendered, and not the types of practitioners who may provide services.

The second reason for concluding that carriers may not exclude an entire category of providers is that such a construction of the statute would violate the clear legislative intent to prohibit discrimination among categories of providers. Several sections of the insurance code address this subject; all of them must be considered together in order to ascertain legislative policy and intent.(29)

For example, RCW 48.44.309 contains the legislative finding that health plans "may be anticompetitive because of the exclusion of other licensed forms of health care and that because of the high costs of health care, there is a need for competition to reduce these costs." No single category of practitioners should be allowed to monopolize the provision of health care; the public has an interest in "assuring the people of the state access to health care services of their choice." RCW 48.44.299. The means by which the legislature has chosen to accomplish this goal is to ban discrimination. Accordingly:

There shall not be imposed upon one class of doctors providing health care services as defined by this chapter any requirement that is not imposed upon all other doctors providing the same or similar health care services within the scope of their license.

RCW 48.44.300.

For a carrier to exclude one category of providers on grounds that some of the services which those providers are licensed to perform are not efficacious or cost effective will be discriminatory unless all categories of providers are subject to the same test. Yet this is not done. M.D.s, for example, are licensed to perform many services which carriers have determined are not clinically efficacious or cost effective.(30) This does not result in the exclusion of *all* services performed by M.D.s. To treat other providers differently would constitute impermissible discrimination.

The third and final reason that a plan may not exclude an entire category of providers on grounds of efficaciousness is that such an exclusion would have the effect of substituting the carrier's judgment for that of the Legislature. The state has, by law, determined that all of the categories of providers covered by RCW 48.43.045 are *entitled* to "practice health or health-related services" within the scope of their license. RCW 48.43.005(6)(a). If a health provider engages in unprofessional conduct, the Department of Health may revoke that provider's license, impose a fine, or obtain an injunction against further practice. RCW 18.130.160 and 18.130.185. However, the use of a "nontraditional treatment by itself shall not

constitute unprofessional conduct, provided that it does not result in injury to a patient or create an unreasonable risk that a patient may be harmed." RCW 18.130.180(4). The state, not the insurance industry, is the proper guardian of public health and safety.(31) It would be inconsistent with this regulatory structure to allow a carrier to substitute its judgment regarding the value of particular health services for that of the Department of Health or the patient.

For all of the foregoing reasons, RCW 48.43.045 must be interpreted in a nondiscriminatory manner, so that all categories of providers are subject to the same fiscal, medical and administrative standards.

b. The Meaning of "Standards."

This interpretation of the statute is consistent with the way in which carriers currently handle claims submitted by traditional health care providers. Carriers typically have established procedures (often written) governing the manner in which providers must obtain preauthorization, perform services, and/or submit billings if they wish to be reimbursed. Sometimes, these subjects are addressed in carriers' contracts with providers, or in contracts between individual providers and the networks (preferred provider organizations, or "PPOs") to which they belong. In addition, the types of subjects enumerated in subsections (1)(b)(i)-(iii) of the statute may be addressed in the context of manuals which carriers prepare and distribute to providers and/or their own internal claims review staff.

Given the widespread existence of these written procedures within the field of health insurance, and their applicability to subjects addressed in RCW 48.43.045 (1)(b), it is reasonable to presume that these were what the legislature envisioned when it used the word "standards."(32)

This does not mean that every service performed by every provider must be reimbursed in full. For example, a carrier could decide – based on standards of clinical efficaciousness or cost effectiveness – that acupuncture will never be covered, for any patient, as a treatment for a particular condition, such as the common cold. However, if a carrier chooses to exclude a particular treatment on grounds such as these, then it must apply the criteria in a nondiscriminatory manner. In other words, the carrier must be prepared to show that any treatments that *are* authorized for the common cold *are* efficacious and cost effective. Only in this way can the carrier comply with the fundamental statutory requirement that it treat all categories of providers equally.

In essence, this provision reaffirms a carrier's right to review a patient's medical records and determine that a specific treatment is not medically necessary *for that patient*. All providers are familiar with this type of determination, made on an individualized, case-by-case basis, with reference to familiar concepts of medical necessity and cost-effectiveness. The Legislature has merely codified the requirement that newly-included categories of providers agree to abide by the same type of rules.

FINDING #3: RCW 48.43.045 does not permit petitioners to exclude an entire category of providers based on their determination that certain of the providers' services are not cost-effective or clinically efficacious.

QUESTION #4: Benefit Limits.

If a carrier may not exclude an entire category of providers, may it nonetheless place a quantitative limit on the services which that type of provider renders to a policyholder? For example, several of the contract forms filed with the OIC for use in 1996 limit "alternative" medical services to $500 or $1,000 per year, or else they limit the patient to a specific number of treatments. *See e.g.* AR 870 (Blue Cross) and AR 997 (MSC).

a. Permissible Limits – Individual Services.

RCW 48.43.045 does not prohibit policy limits, either in the form of an annual benefit cap or in the form of a lifetime maximum. Thus, petitioners can put limits on an individual service. For example, a recently-filed Blue Cross policy limits in-home "acute nursing services" to a maximum of $2,500 per/year. AR 867. Similar limits may be placed on other specific services. However, the OIC reviews all contract filings to ensure that they are not misleading, and do not promise benefits which are illusory or unreasonable in light of the premium charged.(33) A policy which contains an unreasonably low cap on a particular service – such that the service is effectively excluded from the plan altogether – will be disapproved on this basis.

b. Impermissible Limits: Groups of Services and Limits on Providers.

Another type of benefit limit is one which lumps together a diverse group of services – for example, acupuncture and nutritional counseling – and then imposes a dollar limit on the entire group. *See, e.g.* AR 870. This type of benefit limit discriminates against the services involved based on their perceived status as "alternative." Traditional physicians' services are not subject to this type of grouping and limitation. (34) Moreover, it interferes with a meaningful determination, by the OIC, of the reasonableness of the limit imposed. Thus, if petitioners wish to limit services, they must impose a separate limit for each service involved.

Finally, there are limits imposed not on *services*, but on the types of *providers* who may render those services. Limits that are specific to one category of providers – like outright exclusions of categories of providers – are impermissibly discriminatory.(35) RCW 48.43.045 prohibits the exclusion or limitation of any category (or group of categories) of providers, so long as those providers are licensed and acting within the scope of their practice.

FINDING #4: RCW 48.43.045 does not prohibit petitioners from placing reasonable limits on individual services. However, the OIC will disapprove any policy form which contains unreasonable limits. And, petitioners may not place any limits on the type of licensed provider who is permitted to render covered services.

QUESTION #5. Optional Supplemental Benefits.

Petitioners have suggested that it would be possible for them to comply with RCW 48.43.045 by offering

policyholders an opportunity to purchase a separately priced policy rider which would cover various "alternative" providers. Yet treating the "every category" mandate as an optional benefit would violate the clear language chosen by the Legislature. The statute on its face applies to "every" health plan. This is the language of a "mandatory benefit," not a "mandatory offering" – a distinction that is made throughout the insurance code.

Certain benefits, such as mammography, must be *contained* in every health plan sold in this state. *See* RCW 48.20.393, 48.21.225, 48.44.325, and 48.46.275. In articulating such requirements, the legislature uses phrases such as "[e]ach health care service contract . . . shall provide benefits for . . . mammography services . . . [.]" RCW 48.44.325. By law, the consumer does not choose whether or not to purchase mammography benefits – they are required in every contract.

Other types of care, such as mental health, must merely be *offered* to the policyholder, who then has the option to accept or decline the specific type of coverage. RCW 48.21.240(2), 48.44.340(2), 48.46.290(2).(36) When the legislature intends to create such a "mandatory offering," the statutory language reflects that the choice belongs to the consumer. For example, "[e]ach health care service contractor . . . shall *offer optional supplemental* coverage for mental health . . . [.]" RCW 48.44.340(1) (emphasis added).

Consistent with these other statutes, the legislature *could* have chosen merely to make "alternative" health care an option for consumers – that is, a "mandatory offering" – by providing that "every health plan . . . shall offer

optional supplemental coverage permitting every category of provider to treat conditions covered by the BHP." But this was not the language chosen. Rather, the statute focuses on the legislative goal of protecting providers against discrimination, requiring that every category of *"provider"* by [sic] permitted to render services.(37) This requirement cannot be satisfied merely by offering policyholders a separately priced rider; every policy must actually include all categories of providers.

FINDING #5: Petitioners may not comply with RCW 48.43.045 by offering the services of certain categories of providers as a separately priced optional benefit.

Order

Based on the foregoing, IT IS HEREBY ORDERED THAT:

1. **Statutory Scope.** RCW 48.43.045(1)(a) requires that petitioners cover all services or care (i.e., treatments) rendered by licensed providers, acting within their scope of practice, for conditions covered by the BHP. A carrier may exclude a particular service unless, by so doing, it substantially excludes an entire category of providers.

2. **Plans Covered**. All health plans, except the Model Plans (i.e., BHP look-alikes) must comply with RCW 48.43.045.

3. **Provider Standards**. RCW 48.43.045 does not permit petitioners to exclude an entire category of providers based on petitioners' determination that the providers' services are not cost-effective or clinically efficacious.

4. **Limitations on Services**. RCW 48.43.045 does not prohibit petitioners from placing reasonable limits on

individual services rendered by specific categories of provider. However, the OIC will disapprove any policy form which contains unreasonable limits. And, petitioners may not place any limits on the type of licensed provider who is permitted to render covered services.

5. Optional Benefits. Petitioners may not comply with RCW 48.43.045 by offering the services of certain categories of providers as a separately priced optional benefit.

ENTERED on August 21, 1996 at Olympia, Washington.

DEBORAH SENN

Insurance Commissioner

Order G96-13 End Notes

1. Citations to the Administrative Record will be in the form "AR ___." *See* Declaration of Deborah Senn in Opposition to Summary Judgment (AR 1177-1202), at paragraph 4; Affidavit of Pam Martin in Opposition to Summary Judgment (AR 1203-1217) at paragraphs 4-9; and OIC correspondence with health carriers (AR 678-836).

2. Health carriers are required to submit their health plans to the OIC for review. RCW 48.18.100 (disability insurers); 48.44.020 (health care service contractors); 48.46.060 (HMOs); and Chapter 284-58 WAC.

3. For example, some plans explicitly exclude entire categories of providers, while others place contractual

dollar limits, or "caps," on services provided by particular categories of providers. *See, e.g.* AR 870 (Blue Cross); AR 997 (MSC).

4. Also, in February of 1996, the OIC conducted two hearings on issues specific to chiropractors; some of which overlap with the concerns of other categories of health care providers. The transcripts and sign-in sheets from these hearings are at AR 1339-1417.

5. *See* RCW 48.18.100; 48.44.020; 48.46.060 and Chapter 284-58 WAC.

6. *See* RCW 48.18.110(2); 48.44.020(2); 48.46.060(3).

7. For convenience, the entire text of the 1993 health care reforms (many now repealed) is reproduced at AR 1-188.

8. For details on the Basic Health Plan, see infra at p. 11 and n. 13.

9. The 1993 Act also contained a provision protecting providers from being excluded from health carriers' networks. *See* 1993 Wash. Laws Ch. 492, section 431, formerly codified at RCW 48.43.170. This provision was repealed in 1995 and is not at issue herein.

10. "The [1993] legislature intends that . . . state residents be able to choose health services from the *full range* of health care providers, as defined in [former] RCW 43.72.010(12) . . . [.]" 1993 Wash. Laws Ch. 492, section 102(2)(c).

11. In the 1993 Act, the phrase "certified health plan" meant every disability insurer, health care service contractor, or HMO. *See* RCW 43.72.010(1) (repealed 1995)

(definition); 43.72.090 (repealed 1995) (certification requirement). The 1995 legislation substituted the term "health carrier" for such entities, and "health plan" for the products which they market. RCW 48.43.005(8) and (9).

12. The UBP was the minimum package of benefits that all plans were required to cover. RCW 43.72.130 (repealed 1995).

13. The most recent version of this schedule is reproduced at AR 1588-1606. RCW 70.47.060 authorizes the HCA to create a "schedule of covered basic health care services" listing the treatments to which BHP enrollees are entitled. By definition, this schedule is the same as the "basic health plan services" – the term used in the "every category" statute. *See* RCW 48.43.005(1). Thus, the reference to "conditions included in the basic health plan services" contained in RCW 48.43.045 translates into a simpler phase: "Conditions covered by the BHP."

The financial cost of particular services is a significant factor in the HCA's choices of which services to include. *Id.* (citing considerations contained in RCW 48.42.080). This emphasis on frugality is consistent with the fundamental purpose of the BHP, which is to provide affordable care to the working poor. *See* RCW 70.47.010(2). Thus, the BHP excludes some of the services valued by policyholders who enjoy the luxury of purchasing their own, more expensive, health insurance plans.

14. "In construing any statute, we should attempt to give effect to the plain meaning of the words the Legislature has used." *State v. Sommerville*, 111 Wn.2d 524, 531

(1988) (citing *Addleman v. Bd. of Prison Terms and Paroles*, 107 Wn.2d 503, 509 (1986)).

15. That is, how Beaver Cleaver gets to the store.

16. *See Cox v. Helenius*, 103 Wn.2d 383, 387-388 (1985) (citing, *inter alia*, 2A Sands, *Statutory Construction*, Sec. 46.06, at 63 (4th ed. 1973); *Gross v. Lynnwood*, 90 Wn.2d 395, 398-399 (1978).

17. *See also State v. Hill*, 48 Wn. App. 344, 350, *review denied* 109 Wn.2d 1018 (1987) (citing *Boeing Co. v. Dep't of Licensing*, 103 Wn.2d 581, 587 (1985) and *Davis v. Gibbs*, 39 Wn.2d 481, 483 (1951)); and *In re Sehome Park Care Center*, 127 Wn.2d 774, 782 (1995).

18. Petitioners' reading also yields an absurdity. If "included in the [BHP]" only modifies "conditions" – not "services" – then the statute mandates the coverage of all services without limiting its mandate in any way. It is highly unlikely that this was the Legislature's intent, or that petitioners would advocate this result.

19. " 'Health care service' means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury or disease." RCW 48.43.005 (7).

20. *State v. Roth*, 78 Wn.2d 711, 715 (1971); *see also State v. Rains*, 87 Wn.2d 626 (1976).

21. There was nothing inevitable about the selection of the BHP as a source for a list of conditions. Instead, the legislature could have used any health plan, such as the Uniform Plan which insures state employees. The important thing is that the legislature focused on the *conditions* covered by that plan – whether it be the BHP, the UBP the

Uniform Plan, or "Plan X." This focus on conditions has remained constant throughout the history of the "every category" statute.

22. Even if the BHP did not contain any exclusions, the OIC would not be able to rewrite the statute merely because the agency disagreed with its wisdom. *Burlington Northern, Inc. v. Johnston*, 89 Wn.2d 321, 326, 332 (1977) (agency may interpret statutes, but may not alter or amend them); *Cole v. WUTC*, 79 Wn.2d 302 (1971) (same).

23. Nothing in the Insurance Code precludes a carrier from offering, or an individual from purchasing, plans which have more or less comprehensive benefits than the BHP. *See* RCW 48.20.028(1)(a); 48.21.045(1)(a); 48.44.023(1)(a); and 48.46.066(1)(a).

24. "While the literal reading of a statute or ordinance is usually controlling, such is not the case if the literal language is not in accord with the obvious legislative intent." *Silver Shores Mobile Home Park, Inc. v. Everett*, 87 Wn.2d 618, 620 (1976) (citing with approval *Lenci v. Seattle*, 63 Wn.2d 664 (1964) and *In re: Horse Heaven Irr. Dist.*, 11 Wn.2d 218 (1941)).

25. It would be beyond the scope of this order to enumerate all of the exclusions which might have such an effect. For purposes of example, however, the services of acupuncture or clinical massage cannot be excluded, because such an exclusion would have the effect of substantially excluding acupuncturists and licensed massage therapists.

26. Moreover, this exact limitation was proposed, and defeated, in the 1996 legislative session. *See* AR 501-546 (legislative history of SHB 2097).

27. *In re: Little*, 106 Wn.2d 269, 284 (1986); *McKinnon v. White*, 40 Wn. App. 184, 193 (1985).

28. *JJR v. Seattle*, 126 Wn.2d 1, 10 (1995) (citing *State v. McCullum*, 98 Wn.2d 484, 493 (1983)).

29. *See Bennett v. Hardy*, 113 Wn.2d 912, 926-927 (1990) (considering statements of policy enunciated in RCW 49.60 in construing RCW 48.44.090; *In re Marriage of Little*, 96 Wn.2d 183, 189 (1981) (citing numerous cases "enunciating the principle that, in construing a legislative enactment, the entire sequence of all enactments should be examined to ascertain the legislative policy and intent.")

30. For example, an M.D. will not be reimbursed if she orders an MRI for every patient who complains of occasional mild headaches.

31. *See Ford v. Bellingham-Whatcom Bd. of Health*, 16 Wn. App. 709, 712 (1977) (public health and sanitation are objects of the police power of the state, and their protection is an important function of government, citing 7 E. McQuillan, *The Law of Municipal Corporations*, section 24.219 (3d ed. rev. 1968)); *Snohomish County Builders' Ass'n v. Snohomish Health Dist.*, 8 Wn. App. 589, 594-595 (1973) (underscoring county's authority to regulate public health; laws in this area are to be construed broadly).

32. When a statute incorporates words having a special meaning within the field which the statute regulates, it is proper to explain those words by reference to

the industry from which they originated. *Corning Glass Works v. Brennan*, 417 U.S. 188, 201-202, 94 S. Ct. 2223 (1974) (interpreting term "working conditions" as used in Equal Pay Act of 1963); *McDermott Int'l Inc. v. Wilander*, 498 U.S. 340, 342-43 (1991) (interpreting "seaman" as used in Jones Act).

33. *See* RCW 48.18.110(1)(d), (2); 48.44.020(2)(e),(f); and 48.46.060(d)(e). A policy is misleading if it purports to cover a particular condition (for example, pregnancy) but then imposes a limit on that coverage which is so low that, in effect, coverage is excluded altogether.

An example would be a policy which purported to cover pregnancy, but then placed a $500 limit on that coverage. *See* RCW 48.18.110(1)(c),(d) and (2); 48.44.020(2)(a), (d) and (e); and 48.46.060(a), (d) and (e).

34. For example, insurance policies do not lump together such diverse services as emergency room services, pap smears, and chemotherapy – and then impose a cap on the entire group.

35. *See supra* at pp. 16-17.

36. *See also* RCW 48.21.220(2) and 48.44.320(2) (home and hospice care); RCW 48.21.320, 48.44.460, 48.46.530 (TMJ).

37. *See supra* at pp. 16-17.

48.20.002 Scope of chapter. Nothing in this chapter shall apply to or affect (1) any policy of workers' compensation insurance or any policy of liability insurance with or without supplementary expense coverage therein; or (2) any policy or contract of reinsurance; or (3) any blanket or group policy of insurance; or (4) life insurance, endowment or annuity contracts, or contracts supplemental thereto which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract. [1987 c 185 § 25; 1951 c 229 § 1.]

48.20.012 Format of disability policies. No disability policy shall be delivered or issued for delivery to any person in this state unless it otherwise complies with this code, and complies with the following:

(1) It shall purport to insure only one person, except as to family expense insurance written pursuant to RCW 48.20.340.

(2) The style, arrangement and over-all appearance of the policy shall give no undue prominence to any portion of the text, and every printed portion of the text of the policy and of any endorsements or attached papers shall be plainly printed in light-faced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lower-case unspaced alphabet length not less than one hundred and twenty-point (the

"text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and caption and subcaptions).

(3) The exceptions and reductions of indemnity shall be set forth in the policy and, other than those contained in RCW 48.20.042 to 48.20.272, inclusive, shall be printed, at the insurer's option, either included with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions," or "Exceptions and reductions," except that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies.

(4) Each such form, including riders and endorsements, shall be identified by a form number in the lower left hand corner of the first page thereof.

(5) It shall contain no provision purporting to make any portion of the insurer's charter, rules, constitution, or bylaws a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner. [1951 c 229 § 2; 1947 c 79 § .20.02; formerly Rem. Supp. 1949 § 45.20.02.]

48.20.013 Return of policy and refund of premium – Notice required – Effect of return. Every individual disability insurance policy issued after January 1, 1968, except single premium nonrenewable policies, shall have printed on its face or attached thereto a notice stating in substance that the person to whom the policy is issued shall be permitted to return the policy within ten days of

its delivery to the purchaser and to have the premium paid refunded if, after examination of the policy, the purchaser is not satisfied with it for any reason. An additional ten percent penalty shall be added to any premium refund due which is not paid within thirty days of return of the policy to the insurer or agent. If a policy holder or purchaser pursuant to such notice, returns the policy to the insurer at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. [1983 1st ex.s. c 32 § 9; 1967 c 150 § 26.]

48.20.015 Endorsements. If a contract is issued on any basis other than as applied for, an endorsement setting forth such modification(s) must accompany and be attached to the policy; and no endorsement shall be effective unless signed by the policyowner, and a signed copy thereof returned to the insurer. [1975 1st ex.s. c 266 § 9.]

48.20.022 Policies issued by domestic insurer for delivery in another state. If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public official of such other state has advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may by ruling require that such policy meet the applicable standards set forth in this chapter and in chapter 48.18 RCW. [1951 c 229 § 3.]

48.20.028 Mandatory offering to individuals providing basic health plan benefits – Exemption from statutory requirements – Premium rates – Definitions. (1)(a)

An insurer offering any health benefit plan to any individual shall offer and actively market to all individuals a health benefit plan providing benefits identical to the schedule of covered health benefits that are required to be delivered to an individual enrolled in the basic health plan subject to RCW 48.43.025 and 48.43.035. Nothing in this subsection shall preclude an insurer from offering, or an individual from purchasing, other health benefit plans that may have more or less comprehensive benefits than the basic health plan, provided such plans are in accordance with this chapter. An insurer offering a health benefit plan that does not include benefits provided in the basic health plan shall clearly disclose these differences to the individual in a brochure approved by the commissioner.

(b) A health benefit plan shall provide coverage for hospital expenses and services rendered by a physician licensed under chapter 18.57 or 18.71 RCW but is not subject to the requirements of RCW 48.20.390, 48.20.393, 48.20.395, 48.20.397, 48.20.410, 48.20.411, 48.20.412, 48.20.416, and 48.20.420 if the health benefit plan is the mandatory offering under (a) of this subsection that provides benefits identical to the basic health plan, to the extent these requirements differ from the basic health plan.

(2) Premiums for health benefit plans for individuals shall be calculated using the adjusted community rating method that spreads financial risk across the carrier's entire individual product population. All such rates shall conform to the following:

(a) The insurer shall develop its rates based on an adjusted community rate and may only vary the adjusted community rate for:

(i) Geographic area;

(ii) Family size;

(iii) Age;

(iv) Tenure discounts; and

(v) Wellness activities.

(b) The adjustment for age in (a)(iii) of this subsection may not use age brackets smaller than five-year increments which shall begin with age twenty and end with age sixty-five. Individuals under the age of twenty shall be treated as those age twenty.

(c) The insurer shall be permitted to develop separate rates for individuals age sixty-five or older for coverage for which medicare is the primary payer and coverage for which medicare is not the primary payer. Both rates shall be subject to the requirements of this subsection.

(d) The permitted rates for any age group shall be no more than four hundred twenty-five percent of the lowest rate for all age groups on January 1, 1996, four hundred percent on January 1, 1997, and three hundred seventy-five percent on January 1, 2000, and thereafter.

(e) A discount for wellness activities shall be permitted to reflect actuarially justified differences in utilization or cost attributed to such programs not to exceed twenty percent.

(f) The rate charged for a health benefit plan offered under this section may not be adjusted more frequently than annually except that the premium may be changed to reflect:

(i) Changes to the family composition;

(ii) Changes to the health benefit plan requested by the individual; or

(iii) Changes in government requirements affecting the health benefit plan.

(g) For the purposes of this section, a health benefit plan that contains a restricted network provision shall not be considered similar coverage to a health benefit plan that does not contain such a provision, provided that the restrictions of benefits to network providers result in substantial differences in claims costs. This subsection does not restrict or enhance the portability of benefits as provided in RCW 48.43.015.

(h) A tenure discount for continuous enrollment in the health plan of two years or more may be offered, not to exceed ten percent.

(3) Adjusted community rates established under this section shall pool the medical experience of all individuals purchasing coverage, and shall not be required to be pooled with the medical experience of health benefit plans offered to small employers under RCW 48.21.045.

(4) As used in this section, "health benefit plan," "basic health plan," "adjusted community rate," and "wellness activities" mean the same as defined in RCW 48.43.005. [1997 c 231 § 207; 1995 c 265 § 13.]

48.21.010 "Group disability insurance" defined. Group disability insurance is that form of disability insurance, including stop loss insurance as defined in RCW 48.11.030, provided by a master policy issued to an employer, to a trustee appointed by an employer or employers, or to an association of employers formed for purposes other than obtaining such insurance, covering, with or without their dependents, the employees, or specified categories of the employees, of such employers or their subsidiaries or affiliates, or issued to a labor union, or to an association of employees formed for purposes other than obtaining such insurance, covering, with or without their dependents, the members, or specified categories of the members, of the labor union or association, or issued pursuant to RCW 48.21.030. Group disability insurance shall also include such other groups as qualify for group life insurance under the provisions of this code. [1992 c 226 § 2; 1949 c 190 § 27; 1947 c 79 § .21.01; Rem. Supp. 1949 § 45.21.01.]

48.21.015 "Group stop loss insurance" defined – Exemptions to application. Group stop loss insurance is exempt from all sections of this chapter, chapter 48.32A RCW, and chapter 48.41 RCW except for RCW 48.21.010 and this section. For [the] purpose of this exemption, group stop loss is further defined as follows:

(1) The policy must be issued to and insure the employer, the trustee or other sponsor of the plan, or the plan itself, but not the employees, members, or participants;

(2) Payment by the insurer must be made to the employer, the trustee, or other sponsor of the plan or the

plan itself, but not to the employees, members, participants, or health care providers;

(3) The policy must contain a provision that establishes an aggregate attaching point or retention that is at the minimum one hundred twenty percent of the expected claims; and

(4) The policy may provide for an individual attaching point or retention that is not less than five percent of the expected claims or one hundred thousand dollars, whichever is less. [1992 c 226 § 3.]

48.21.020 "Employees," "employer" defined. The term "employees" as used in this chapter shall be deemed to include as employees of a single employer, the compensated officers, managers, and employees of the employer and of subsidiary or affiliated corporations of a corporation employer, and the individual proprietors, partners, and employees of individuals and firms of which the business is controlled by the insured employer through stock ownership, contract or otherwise. The term "employer" as used in this chapter shall be deemed to include any municipal corporation or governmental unit, agency or department thereof as well as private individuals, firms, corporations and other persons. [1947 c 79 § .21.02; Rem. Supp. 1947 § 45.21.02.]

48.21.030 Health care groups. A policy of group disability insurance may be issued to a corporation, as policyholder, existing primarily for the purpose of assisting individuals who are its subscribers in securing medical, hospital, dental, and other health care services for themselves and their dependents, covering all and not less than five hundred such subscribers and dependents, with

respect only to medical, hospital, dental, and other health care services. [1947 c 79 § .21.03; Rem. Supp. 1947 § 45.21.03.]

48.21.040 "Blanket disability insurance" defined. (1) Any policy or contract of disability insurance which conforms with the description and complies with the requirements contained in one of the following six paragraphs shall be deemed a blanket disability insurance policy:

(a) A policy issued to any common carrier of passengers, which carrier shall be deemed the policyholder, covering a group defined as all persons who may become such passengers, and whereby such passengers shall be insured against loss or damage resulting from death or bodily injury either while, or as a result of, being such passengers.

(b) A policy issued in the name of any volunteer fire department, first aid or ambulance squad or volunteer police organization, which shall be deemed the policyholder, and covering all the members of any such organization against loss from accidents resulting from hazards incidental to duties in connection with such organizations.

(c) A policy issued in the name of any established organization whether incorporated or not, having community recognition and operated for the welfare of the community and its members and not for profit, which shall be deemed the policyholder, and covering all volunteer workers who serve without pecuniary compensation and the members of the organization, against loss from

accidents occurring while engaged in the actual performance of duties on behalf of such organization or in the activities thereof.

(d) A policy issued to an employer, who shall be deemed the policyholder, covering any group of employees defined by reference to exceptional hazards incident to such employment, insuring such employees against death or bodily injury resulting while, or from, being exposed to such exceptional hazards.

(e) A policy covering students or employees issued to a college, school, or other institution of learning or to the head or principal thereof, who or which shall be deemed the policyholder.

(f) A policy or contract issued to any other substantially similar group, which, in the commissioner's discretion, may be subject to the insurance of a blanket disability policy or contract.

(2) Nothing contained in this section shall be deemed to affect the liability of policyholders for the death of, or injury to, any such members of such group.

(3) Individual applications shall not be required from individuals covered under a blanket disability insurance contract. [1959 c 225 § 7; 1947 c 79 § .21.04; Rem. Supp. 1947 § 45.21.04.]

48.43.005 Definitions. Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Adjusted community rate" means the rating method used to establish the premium for health plans adjusted to reflect actuarially demonstrated differences in utilization or cost attributable to geographic region, age, family size, and use of wellness activities.

(2) "Basic health plan" means the plan described under chapter 70.47 RCW, as revised from time to time.

(3) "Basic health plan model plan" means a health plan as required in RCW 70.47.060(2)(d).

(4) "Basic health plan services" means that schedule of covered health services, including the description of how those benefits are to be administered, that are required to be delivered to an enrollee under the basic health plan, as revised from time to time.

(5) "Certification" means a determination by a review organization that an admission, extension of stay, or other health care service or procedure has been reviewed and, based on the information provided, meets the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the auspices of the applicable health benefit plan.

(6) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(7) "Covered person" or "enrollee" means a person covered by a health plan including an enrollee, subscriber, policyholder, beneficiary of a group plan, or individual covered by any other health plan.

(8) "Dependent" means, at a minimum, the enrollee's legal spouse and unmarried dependent children who qualify for coverage under the enrollee's health benefit plan.

(9) "Eligible employee" means an employee who works on a full-time basis with a normal work week of thirty or more hours. The term includes a self-employed individual, including a sole proprietor, a partner of a partnership, and may include an independent contractor, if the self-employed individual, sole proprietor, partner, or independent contractor is included as an employee under a health benefit plan of a small employer, but does not work less than thirty hours per week and derives at least seventy-five percent of his or her income from a trade or business through which he or she has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form. Persons covered under a health benefit plan pursuant to the consolidated omnibus budget reconciliation act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements of chapter 265, Laws of 1995.

(10) "Emergency medical condition" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure

to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(11) "Emergency services" means otherwise covered health care services medically necessary to evaluate and treat an emergency medical condition, provided in a hospital emergency department.

(12) "Enrollee point-of-service cost-sharing" means amounts paid to health carriers directly providing services, health care providers, or health care facilities by enrollees and may include copayments, coinsurance, or deductibles.

(13) "Grievance" means a written complaint submitted by or on behalf of a covered person regarding: (a) Denial of payment for medical services or nonprovision of medical services included in the covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier.

(14) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter

70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state and such other facilities as required by federal law and implementing regulations.

(15) "Health care provider" or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(16) "Health care service" means that service offered or provided by health care facilities and health care providers relating to the prevention, cure, or treatment of illness, injury, or disease.

(17) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, or a health maintenance organization as defined in RCW 48.46.020.

(18) "Health plan" or "health benefit plan" means any policy, contract, or agreement offered by a health carrier to provide, arrange, reimburse, or pay for health care services except the following:

(a) Long-term care insurance governed by chapter 48.84 RCW;

(b) Medicare supplemental health insurance governed by chapter 48.66 RCW;

(c) Limited health care services offered by limited health care service contractors in accordance with RCW 48.44.035;

(d) Disability income;

(e) Coverage incidental to a property/casualty liability insurance policy such as automobile personal injury protection coverage and homeowner guest medical;

(f) Workers' compensation coverage;

(g) Accident only coverage;

(h) Specified disease and hospital confinement indemnity when marketed solely as a supplement to a health plan;

(i) Employer-sponsored self-funded health plans;

(j) Dental only and vision only coverage; and

(k) Plans deemed by the insurance commissioner to have a short-term limited purpose or duration, or to be a student-only plan that is guaranteed renewable while the covered person is enrolled as a regular full-time undergraduate or graduate student at an accredited higher education institution, after a written request for such classification by the carrier and subsequent written approval by the insurance commissioner.

(19) "Material modification" means a change in the actuarial value of the health plan as modified of more than five percent but less than fifteen percent.

(20) "Open enrollment" means the annual sixty-two day period during the months of July and August during which every health carrier offering individual health plan coverage must accept onto individual coverage any state resident within the carrier's service area regardless of health condition who submits an application in accordance with RCW 48.43.035(1).

(21) "Preexisting condition" means any medical condition, illness, or injury that existed any time prior to the effective date of coverage.

(22) "Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" shall not include amounts paid as enrollee point-of-service cost-sharing.

(23) "Review organization" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, health care service contractor as defined in RCW 48.44.010, or health maintenance organization as defined in RCW 48.46.020, and entities affiliated with, under contract with, or acting on behalf of a health carrier to perform a utilization review.

(24) "Small employer" means any person, firm, corporation, partnership, association, political subdivision

except school districts, or self-employed individual that is actively engaged in business that, on at least fifty percent of its working days during the preceding calendar quarter, employed no more than fifty eligible employees, with a normal work week of thirty or more hours, the majority of whom were employed within this state, and is not formed primarily for purposes of buying health insurance and in which a bona fide employer-employee relationship exists. In determining the number of eligible employees, companies that are affiliated companies, or that are eligible to file a combined tax return for purposes of taxation by this state, shall be considered an employer. Subsequent to the issuance of a health plan to a small employer and for the purpose of determining eligibility, the size of a small employer shall be determined annually. Except as otherwise specifically provided, a small employer shall continue to be considered a small employer until the plan anniversary following the date the small employer no longer meets the requirements of this definition. The term "small employer" includes a self-employed individual or sole proprietor. The term "small employer" also includes a self-employed individual or sole proprietor who derives at least seventy-five percent of his or her income from a trade or business through which the individual or sole proprietor has attempted to earn taxable income and for which he or she has filed the appropriate internal revenue service form 1040, schedule C or F, for the previous taxable year.

(25) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care

resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.

(26) "Wellness activity" means an explicit program of an activity consistent with department of health guidelines, such as, smoking cessation, injury and accident prevention, reduction of alcohol misuse, appropriate weight reduction, exercise, automobile and motorcycle safety, blood cholesterol reduction, and nutrition education for the purpose of improving enrollee health status and reducing health service costs. [1997 c 231 § 202; 1997 c 55 § 1; 1995 c 265 § 4.]

48.43.045 Health plan requirements – Annual reports – Exemptions. Every health plan delivered, issued for delivery, or renewed by a health carrier on and after January 1, 1996, shall:

(1) Permit every category of health care provider to provide health services or care for conditions included in the basic health plan services to the extent that:

(a) The provision of such health services or care is within the health care providers' permitted scope of practice; and

(b) The providers agree to abide by standards related to:

(i) Provision, utilization review, and cost containment of health services;

(ii) Management and administrative procedures; and

(iii) Provision of cost-effective and clinically efficacious health services.

(2) Annually report the names and addresses of all officers, directors, or trustees of the health carrier during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals. This requirement does not apply to a foreign or alien insurer regulated under chapter 48.20 or 48.21 RCW that files a supplemental compensation exhibit in its annual statement as required by law. [1997 c 231 § 205; 1995 c 265 § 8.]

Short title – Part headings and captions not law – Severability – Effective dates – 1997 c 231: See notes following RCW 48.43.005.

Captions not law – Effective dates – Savings – Severability – 1995 c 265: See notes following RCW 70.47.015.

48.44.010 Definitions. For the purposes of this chapter:

(1) "Health care services" means and includes medical, surgical, dental, chiropractic, hospital, optometric, podiatric, pharmaceutical, ambulance, custodial, mental health, and other therapeutic services.

(2) "Provider" means any health professional, hospital, or other institution, organization, or person that furnishes health care services and is licensed to furnish such services.

(3) "Health care service contractor" means any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services.

(4) "Participating provider" means a provider, who or which has contracted in writing with a health care service contractor to accept payment from and to look solely to such contractor according to the terms of the subscriber contract for any health care services rendered to a person who has previously paid, or on whose behalf prepayment has been made, to such contractor for such services.

(5) "Enrolled participant" means a person or group of persons who have entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health care service contractor to receive health care services.

(6) "Commissioner" means the insurance commissioner.

(7) "Uncovered expenditures" means the costs to the health care service contractor for health care services that are the obligation of the health care service contractor for which an enrolled participant would also be liable in the event of the health care service contractor's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant even though the provider is not paid by the health care service contractor, or for services that are guaranteed, insured or assumed by a person or organization other than the health care service contractor.

(8) "Copayment" means an amount specified in a group or individual contract which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(9) "Deductible" means the amount an enrolled participant is responsible to pay before the health care service contractor begins to pay the costs associated with treatment.

(10) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specific group. The group contract may include coverage for dependents.

(11) "Individual contract" means a contract for health care services issued to and covering an individual. An individual contract may include dependents.

(12) "Carrier" means a health maintenance organization, an insurer, a health care service contractor, or other entity responsible for the payment of benefits or provision of services under a group or individual contract.

(13) "Replacement coverage" means the benefits provided by a succeeding carrier.

(14) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(15) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.44.037(3) and are recorded as equity.

(16) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt. [1990 c 120 § 1; 1986c 223 § 1. Prior: 1983 c 286 § 3; 1983 c 154 § 3; 1980 c 102 § 10; 1965 c 87 § 1; 1961 c 197 § 1; 1947 c 268 § 1; Rem. Supp. 1947 § 6131-10.]

48.46.020 Definitions. As used in this chapter, the terms defined in this section shall have the meanings indicated unless the context indicates otherwise.

(1) "Health maintenance organization" means any organization receiving a certificate of registration by the commissioner under this chapter which provides comprehensive health care services to enrolled participants of such organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a health maintenance organization pursuant to RCW 48.46.030 and 48.46.040.

(2) "Comprehensive health care services" means basic consultative, diagnostic, and therapeutic services rendered by licensed health professionals together with emergency and preventive care, inpatient hospital, outpatient and physician care, at a minimum, and any additional health care services offered by the health maintenance organization.

(3) "Enrolled participant" means a person who or group of persons which has entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health maintenance organization to receive health care services.

(4) "Health professionals" means health care practitioners who are regulated by the state of Washington.

(5) "Health maintenance agreement" means an agreement for services between a health maintenance organization which is registered pursuant to the provisions of this chapter and enrolled participants of such organization which provides enrolled participants with comprehensive health services rendered to enrolled participants by health professionals, groups, facilities, and other personnel associated with the health maintenance organization.

(6) "Consumer" means any member, subscriber, enrollee, beneficiary, or other person entitled to health care services under terms of a health maintenance agreement, but not including health professionals, employees of health maintenance organizations, partners, or shareholders of stock corporations licensed as health maintenance organizations.

(7) "Meaningful role in policy making" means a procedure approved by the commissioner which provides consumers or elected representatives of consumers a means of submitting the views and recommendations of such consumers to the governing board of such organization coupled with reasonable assurance that the board will give regard to such views and recommendations.

(8) "Meaningful grievance procedure" means a procedure for investigation of consumer grievances in a timely manner aimed at mutual agreement for settlement according to procedures approved by the commissioner, and which may include arbitration procedures.

(9) "Provider" means any health professional, hospital, or other institution, organization, or person that

furnishes any health care services and is licensed or otherwise authorized to furnish such services.

(10) "Department" means the state department of social and health services.

(11) "Commissioner" means the insurance commissioner.

(12) "Group practice" means a partnership, association, corporation, or other group of health professionals:

(a) The members of which may be individual health professionals, clinics, or both individuals and clinics who engage in the coordinated practice of their profession; and

(b) The members of which are compensated by a prearranged salary, or by capitation payment or drawing account that is based on the number of enrolled participants.

(13) "Individual practice health care plan" means an association of health professionals in private practice who associate for the purpose of providing prepaid comprehensive health care services on a fee-for-service or capitation basis.

(14) "Uncovered expenditures" means the costs to the health maintenance organization of health care services that are the obligation of the health maintenance organization for which an enrolled participant would also be liable in the event of the health maintenance organization's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant

even though the provider is not paid by the health maintenance organization, or for services that are guaranteed, insured, or assumed by a person or organization other than the health maintenance organization.

(15) "Copayment" means an amount specified in a subscriber agreement which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(16) "Deductible" means the amount an enrolled participant is responsible to pay out-of-pocket before the health maintenance organization begins to pay the costs associated with treatment.

(17) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.46.235(3) and are recorded as equity.

(18) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

(19) "Participating provider" means a provider as defined in subsection (9) of this section who contracts with the health maintenance organization or with its contractor or subcontractor and has agreed to provide health care services to enrolled participants with an expectation of receiving payment, other than copayment or deductible, directly or indirectly, from the health maintenance organization.

(20) "Carrier" means a health maintenance organization, an insurer, a health care services contractor, or other entity responsible for the payment of benefits or

provision of services under a group or individual agreement.

(21) "Replacement coverage" means the benefits provided by a succeeding carrier.

(22) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction. [1990 c 119 § 1; 1983 c 106 § 1; 1982 c 151 § 1; 1975 1st ex.s. c 290 § 3.]

48.47.005 Legislative findings – Purpose. The legislature finds that there is a continued interest in mandating certain health coverages or offering of health coverages by health carriers; and that improved access to these health care services to segments of the population which desire them can provide beneficial social and health consequences which may be in the public interest.

The legislature finds further, however, that the cost ramifications of expanding health coverages is of continuing concern; and that the merits of a particular mandated benefit must be balanced against a variety of consequences which may go far beyond the immediate impact upon the cost of insurance coverage. The legislature hereby finds and declares that a systematic review of proposed mandated benefits, which explores all the ramifications of such proposed legislation, will assist the legislature in determining whether mandating a particular coverage or offering is in the public interest. The purpose of this chapter is to establish a procedure for the proposal, review, and determination of mandated benefit necessity. [1997 c 412 § 1; 1984 c 56 § 1. Formerly RCW 48.42.060.]

48.47.010 Definitions. Unless otherwise specifically provided, the definitions in this section apply throughout this chapter.

(1) "Appropriate committees of the legislature" or "committees" means nonfiscal standing committees of the Washington state senate and house of representatives that

have jurisdiction over statutes that regulate health carriers, health care facilities, health care providers, or health care services.

(2) "Department" means the Washington state department of health.

(3) "Health care facility" or "facility" means hospices licensed under chapter 70.127 RCW, hospitals licensed under chapter 70.41 RCW, rural health care facilities as defined in RCW 70.175.020, psychiatric hospitals licensed under chapter 71.12 RCW, nursing homes licensed under chapter 18.51 RCW, community mental health centers licensed under chapter 71.05 or 71.24 RCW, kidney disease treatment centers licensed under chapter 70.41 RCW, ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW, drug and alcohol treatment facilities licensed under chapter 70.96A RCW, and home health agencies licensed under chapter 70.127 RCW, and includes such facilities if owned and operated by a political subdivision or instrumentality of the state, and such other facilities as required by federal law and implementing regulations.

(4) "Health care provider"~~,~~ or "provider" means:

(a) A person regulated under Title 18 or chapter 70.127 RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law; or

(b) An employee or agent of a person described in (a) of this subsection, acting in the course and scope of his or her employment.

(5) "Health care service" or "service" means a service, drug, or medical equipment offered or provided by a health care facility and a health care provider relating to the prevention, cure, or treatment of illness, injury, or disease.

(6) "Health carrier" or "carrier" means a disability insurer regulated under chapter 48.20 or 48.21 RCW, a health care service contractor as defined in RCW 48.44.010, a health maintenance organization as defined in RCW 48.46.020, plans operating under the state health care authority under chapter 41.05 RCW, the state health insurance pool operating under chapter 48.41 RCW, and insuring entities regulated in chapter 48.43 RCW.

(7) "Mandated health benefit," "mandated benefit," or "benefit" means coverage or offering required by law to be provided by a health carrier to: (a) Cover a specific health care service or services; (b) cover treatment of a specific condition or conditions; or (c) contract, pay, or reimburse specific categories of health care providers for specific services; however, it does not mean benefits established pursuant to chapter 74.09, 41.05, or 70.47 RCW, or scope of practice modifications pursuant to chapter 18.120 RCW. [1997 c 412 § 2.]

48.47.020 Submission of mandated health benefit proposal – Review – Benefit must be authorized by law. Mandated health benefits shall be established as follows:

(1) Every person who, or organization that, seeks to establish a mandated benefit shall, at least ninety days

prior to a regular legislative session, submit a mandated benefit proposal to the appropriate committees of the legislature, assessing the social impact, financial impact, and evidence of health care service efficacy of the benefit in strict adherence to the criteria enumerated in RCW 48.47.030.

(2) The chair of a committee may request that the department examine the proposal using the criteria set forth in RCW 48.47.030, however, such request must be made no later than nine months prior to a subsequent regular legislative session.

(3) To the extent that funds are appropriated for this purpose, the department shall report to the appropriate committees of the legislature on the appropriateness of adoption no later than thirty days prior to the legislative session during which the proposal is to be considered.

(4) Mandated benefits must be authorized by law. [1997 c 412 § 3; 1989 1st ex.s. c 9 § 221; 1987 c 150 § 79; 1984 c 56 § 2. Formerly RCW 48.42.070.]

48.47.030 Mandated health benefit proposal – Guidelines for assessing impact – Inclusion of ad hoc review panels – Health care authority. (1) Based on the availability of relevant information, the following criteria shall be used to assess the impact of proposed mandated benefits:

(a) The social impact: (i) To what extent is the benefit generally utilized by a significant portion of the population? (ii) To what extent is the benefit already generally available? (iii) If the benefit is not generally available, to what extent has its unavailability resulted in persons not receiving needed services? (iv) If the benefit is not generally available, to what extent has its unavailability resulted in unreasonable financial hardship? (v) What is the level of public demand for the benefit? (vi) What is the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts?

(b) The financial impact: (i) To what extent will the benefit increase or decrease the cost of treatment or service? (ii) To what extent will the coverage increase the appropriate use of the benefit? (iii) To what extent will the benefit be a substitute for a more expensive benefit? (iv) To what extent will the benefit increase or decrease the administrative expenses of health carriers and the premium and administrative expenses of policyholders? (v) What will be the impact of this benefit on the total cost of health care services and on premiums for health coverage? (vi) What will be the impact of this benefit on costs for state-purchased health care? (vii) What will be the impact of this benefit on affordability and access to coverage?

(c) Evidence of health care service efficacy:

(i) If a mandatory benefit of a specific service is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the

health consequences of that service compared to no service or an alternative service?

(ii) If a mandated benefit of a category of health care provider is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences achieved by the mandated benefit of this category of health care provider?

(iii) To what extent will the mandated benefit enhance the general health status of the state residents?

(2) The department shall consider the availability of relevant information in assessing the completeness of the proposal.

(3) The department may supplement these criteria to reflect new relevant information or additional significant issues.

(4) The department shall establish, where appropriate, ad hoc panels composed of related experts, and representatives of carriers, consumers, providers, and purchasers to assist in the proposal review process. Ad hoc panel members shall serve without compensation.

(5) The health care authority shall evaluate the reasonableness and accuracy of cost estimates associated with the proposed mandated benefit that are provided to the department by the proposer or other interested parties, and shall provide comment to the department. Interested parties may, in addition, submit data directly to the department. [1997 c 412 § 4; 1984 c 56 § 3. Formerly RCW 48.42.080.]

48.47.900 Severability – 1997 c 412. If any provision of this act or its application to any person or circumstance is held invalid, the remainder of the act or the application of the provision to other persons or circumstances is not affected. [1997 c 412 § 7.]

70.47.015 Expanded enrollment – Findings – Intent – Enrollee premium share – Expedited application and enrollment process – Commission for agents and brokers. (1) The legislature finds that the basic health plan has been an effective program in providing health coverage for uninsured residents. Further, since 1993, substantial amounts of public funds have been allocated for subsidized basic health plan enrollment.

(2) It is the intent of the legislature that the basic health plan enrollment be expanded expeditiously, consistent with funds available in the health services account, with the goal of two hundred thousand adult subsidized basic health plan enrollees and one hundred thirty thousand children covered through expanded medical assistance services by June 30, 1997, with the priority of providing needed health services to children in conjunction with other public programs.

(3) Effective January 1, 1996, basic health plan enrollees whose income is less than one hundred twenty-five percent of the federal poverty level shall pay at least a ten-dollar premium share.

(4) No later than July 1, 1996, the administrator shall implement procedures whereby hospitals licensed under chapters 70.41 and 71.12 RCW, health carrier, rural health care facilities regulated under chapter 70.175 RCW, and community and migrant health centers funded under RCW 41.05.220, may expeditiously assist patients and their families in applying for basic health plan or medical assistance coverage, and in submitting such applications directly to the health care authority or the department of social and health services. The health care authority and

the department of social and health services shall make every effort to simplify and expedite the application and enrollment process.

(5) No later than July 1, 1996, the administrator shall implement procedures whereby health insurance agents and brokers, licensed under chapter 48.17 RCW, may expeditiously assist patients and their families in applying for basic health plan or medical assistance coverage, and in submitting such applications directly to the health care authority or the department of social and health services. Brokers and agents may receive a commission for each individual sale of the basic health plan to anyone not signed up within the previous five years and a commission for each group sale of the basic health plan, if funding for this purpose is provided in a specific appropriation to the health care authority. No commission shall be provided upon a renewal. Commissions shall be determined based on the estimated annual cost of the basic health plan, however, commissions shall not result in a reduction in the premium amount paid to health carriers. For purposes of this section "health carrier" is as defined in RCW 48.43.005. The administrator may establish: (a) Minimum educational requirements that must be completed by the agents or brokers; (b) an appointment process for agents or brokers marketing the basic health plan; or (c) standards for revocation of the appointment of an agent or broker to submit applications for cause, including untrustworthy or incompetent conduct or harm to the public. The health care authority and the department of social and health services shall make every effort to simplify and expedite the application and enrollment process. [1997 c 337 § 1; 1995 c 265 § 1.]

§ 1002. [ERISA §3] Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

* * *

(3) The term "employee benefit plan" or "plan" means an employee welfare benefit plan or an employee pension benefit plan or a plan which is both an employee welfare benefit plan and an employee pension benefit plan.

(4) The term "employee organization" means any labor union or any organization of any kind, or any agency or employee representation committee, association, group, or plan, in which employees participate and which exists for the purpose, in whole or in part, of dealing with employers concerning an employee benefit plan, or other matters incidental to employment relationships; or any

employees' beneficiary association organized for the purpose in whole or in part, of establishing such a plan.

(5) The term "employer" means any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan; and includes a group or association of employers acting for an employer in such capacity.

(6) The term "employee" means any individual employed by an employer.

* * *

(9) The term "person" means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(10) The term "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, and the Canal Zone. The term "United States" when used in the geographic sense means the States and the Outer Continental Shelf lands defined in the Outer Continental Shelf Lands Act (43 U.S.C. 1331-1343).

(11) The term "commerce" means trade, traffic, commerce, transportation, or communication between any State and any place outside thereof.

(12) The term "industry or activity affecting commerce" means any activity, business, or industry in commerce or in which a labor dispute would hinder or obstruct commerce or the free flow of commerce, and includes any activity or industry "affecting commerce" within the

meaning of the Labor Management Relations Act, 1947 [29 U.S.C. 141 et seq.], or the

* * *

(16)(A) The term "administrator" means –

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

* * *

(32) The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or instrumentality of any of the foregoing. The term "governmental plan" also includes any plan to which the

Railroad Retirement Act of 1935, or 1937 [45 U.S.C. 231 et seq.] applies, and which is financed by contributions required under that Act and any plan of an international organization which is exempt from taxation under the provisions of the International Organizations Immunities Act [22 U.S.C. 288 et seq.].

(33)(A) The term "church plan" means a plan established and maintained (to the extent required in clause (ii) of subparagraph (B)) for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of title 26.

* * *

(37)

(A) The term "multiemployer plan" means a plan –

(i) to which more than one employer is required to contribute,

(ii) which is maintained pursuant to one or more collective bargaining agreements between one or more employee organizations and more than one employer, and

(iii) which satisfies such other requirements as the Secretary may prescribe by regulation.

(B) For purposes of this paragraph, all trades or businesses (whether or not incorporated) which are under common control within the meaning of section 1301(b)(1) of this title are considered a single employer.

(C) Notwithstanding subparagraph (A), a plan is a multiemployer plan on and after its termination date if the plan was a multiemployer plan under this paragraph for the plan year preceding its termination date.

(D) For purposes of this subchapter, notwithstanding the preceding provisions of this paragraph, for any plan year which began before September 26, 1980, the term "multiemployer plan" means a plan described in this paragraph (37) as in effect immediately before such date.

(E) Within one year after September 26, 1980, a multiemployer plan may irrevocably elect, pursuant to procedures established by the corporation and subject to the provisions of sections 1453(b) and (c) of this title, that the plan shall not be treated as a multiemployer plan for all purposes under this chapter or the Internal Revenue Code of 1954 if for each of the last 3 plan years ending prior to the effective date of the Multiemployer Pension Plan Amendments Act of 1980 –

(i) the plan was not a multiemployer plan because the plan was not a plan described in subparagraph (A)(iii) of this paragraph and section 414(f)(1)(C) of title 26 (as such provisions were in effect on the day before September 26, 1980); and

(ii) the plan had been identified as a plan that was not a multiemployer plan in substantially all its filings with the corporation, the Secretary of Labor and the Secretary of the Treasury.

* * *

(40)

(A) The term "multiple employer welfare arrangement" means an employee welfare benefit plan, or any other arrangement (other than an employee welfare benefit plan), which is established or maintained for the purpose of offering or providing any benefit described in paragraph (1) to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that such term does not include any such plan or other arrangement which is established or maintained –

(i) under or pursuant to one or more agreements which the Secretary finds to be collective bargaining agreements,

(ii) by a rural electric cooperative, or

(iii) by a rural telephone cooperative association.

(B) for purposes of this paragraph –

(i) two or more trades or businesses, whether or not incorporated, shall be deemed a single employer if such trades or businesses are within the same control group,

(ii) the term "control group" means a group of trades or businesses under common control,

(iii) the determination of whether a trade or business is under "common control" with another trade or business shall be determined under regulations of the Secretary

applying principles similar to the principles applied in determining whether employees of two or more trades or businesses are treated as employed by a single employer under section 1301(b) of this title, except that, for purposes of this paragraph, common control shall not be based on an interest of less than 25 percent,

(iv) the term "rural electric cooperative" means –

(I) any organization which is exempt from tax under section 501(a) of title 26 and which is engaged primarily in providing electric service on a mutual or cooperative basis, and

(II) any organization described in paragraph (4) or (6) of section 501(c) of title 26 which is exempt from tax under section 501(a) of title 26 and at least 80 percent of the members of which are organizations described in subclause (I), and

(v) the term "rural telephone cooperative association" means an organization described in paragraph (4) or (6) of section 501(c) of title 26 which is exempt from tax under section 501(a) of title 26 and at least 80 percent of the members of which are organizations engaged primarily in providing telephone service to rural areas of the United States on a mutual, cooperative, or other basis.

(41) **Single-employer plan.** – The term "single-employer plan" means an employee benefit plan other than a multiemployer plan.

* * *

01/06/97

29 USC Sec. 1003 [ERISA Sec. 4]

Sec. 1003. Coverage

(a) Except as provided in subsection (b) of this section and in sections 1051, 1081, and 1101 of this title, this subchapter shall apply to any employee benefit plan if it is established or maintained –

(1) by any employer engaged in commerce or in any industry or activity affecting commerce; or

(2) by any employee organization or organizations representing employees engaged in commerce or in any industry or activity affecting commerce; or

(3) by both.

(b) The provisions of this subchapter shall not apply to any employee benefit plan if –

(1) such plan is a governmental plan (as defined in section 1002(32) of this title);

(2) such plan is a church plan (as defined in section 1002(33) of this title) with respect to which no election has been made under section 410(d) of this title 26;

(3) such plan is maintained solely for the purpose of complying with applicable workmen's compensation laws or unemployment compensation or disability insurance laws;

(4) such plan is maintained outside of the United States primarily for the benefit of persons substantially all of whom are nonresident aliens; or

(5) such plan is an excess benefit plan (as defined in section 1002(36) of this title) and is unfunded.

The provisions of part 7 of subtitle B shall not apply to a health insurance issuer (as defined in section 1191b(b)(2) of this title) solely by reason of health insurance coverage (as defined in section 1191b(b)(1) of this title) provided by such issuer in connection with a group health plan (as defined in section 1191b(a)(1) of this title) if the provisions of this subchapter do not apply to such group health plan.

29 U.S.C. § 1144. [ERISA § 514] Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) this section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(3) Nothing in this section shall be construed to prohibit use by the Secretary of services or facilities of a State agency as permitted under section 1136 of this title.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(5)(A) Except as provided in subparagraph (B), subsection (a) of this section shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51).

(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section –

(i) any State tax law relating to employee benefit plans, or

(ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.

(C) Notwithstanding subparagraph (A), parts 1 and 4 of this subtitle, and the preceding sections of this part to the extent they govern matters which are governed by the provisions of such parts 1 and 4, shall supersede the Hawaii Prepaid Health Care Act (as in effect on or after January 14, 1983), but the Secretary may enter into cooperative arrangements under this paragraph and section 1136 of this title with officials of the State of Hawaii to assist them in effectuating the policies of provisions of such Act which are superseded by such

parts 1 and 14 and the preceding sections of this part.

(6)(A) Notwithstanding any other provision of this section –

(i) in the case of an employee welfare benefit plan which is a multiple employer welfare arrangement and is fully insured (or which is a multiple employer welfare arrangement subject to an exemption under subparagraph (B)), any law of any State which regulates insurance may apply to such arrangement to the extent that such law provides –

(I) standards, requiring the maintenance of specified levels of reserves and specified levels of contributions, which any such plan, or any trust established under such a plan, must meet in order to be considered under such law able to pay benefits in full when due, and

(II) provisions to enforce such standards, and

(ii) in the case of any other employee welfare benefit plan which is a multiple employer welfare arrangement, in addition to this subchapter, any law of any State which regulates insurance may apply to the extent not inconsistent with the preceding sections of this subchapter.

(B) The Secretary may, under regulations which may be prescribed by the Secretary,

exempt from subparagraph (A)(ii), individually or by class, multiple employer welfare arrangements which are not fully insured. Any such exemption may be granted with respect to any arrangement or class of arrangements only if such arrangement oreach [sic] arrangement which is a member of such class meets the requirements of section 1002(1) and section 1003 of this title necessary to be considered an employee welfare benefit plan to which this subchapter applies.

(C) Nothing in subparagraph (A) shall affect the manner or extent to which the provisions of this subchapter apply to an employee welfare benefit plan which is not a multiple employer welfare arrangement and which is a plan, fund, or program participating in, subscribing to, or otherwise using a multiple employer welfare arrangement to fund or administer benefits to such plan's participants and beneficiaries.

(D) For purposes of this paragraph, a multiple employer welfare arrangement shall be considered fully insured only if the terms of the arrangement provide for benefits the amount of all of which the Secretary determines are guaranteed under a contract, or policy of insurance, issued by an insurance company, insurance service, or insurance organization, qualified to conduct business in a State.

(7) Subsection (a) shall not apply to qualified domestic relations orders (within the meaning of section 206(d)(3)(B)(i)), qualified medical

child support orders (within the meaning of section 609(a)(2)(A), and the provisions of law referred to in section 609(a)(2)(B)(ii) to the extent enforced by qualified medical child support orders.

(8) Subsection (a) of this section shall not be construed to preclude any State cause of action

(A) with respect to which the State exercises its acquired rights under section 609(b)(3) with respect to a group health plan (as defined in section 607(1)), or

(B) for recoupment of payment with respect to items or services pursuant to a State plan for medical assistance approved under title XIX of the Social Security Act which would not have been payable if such acquired rights had been executed before payment with respect to such items or services by the group health plan.

(9) For additional provisions relating to group health plans, see section 731.

(c) Definitions

For purposes of this section:

(1) The term "State law" includes all laws, decisions, rules, regulations, or other State action having the effect of law, of any State. A law of the United States applicable only to the District of Columbia shall be treated as a State law rather than a law of the United States.

(2) The term "State" includes a State, any political subdivisions thereof, or any agency or

instrumentality of either, which purports to regulate, directly or indirectly, the terms and conditions of employee benefit plans covered by this subchapter.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of the United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(c) of this title) or any rule or regulation issued under any such law.

15 USC Sec. *1011*

Sec. 1011. Declaration of policy

Congress hereby declares that the continued regulation and taxation by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation or taxation of such business by the several States.

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15 USC Sec. *1012.* Regulation by State law; Federal relating specifically to insurance; applicability of certain Federal laws after June 30, 1948

(a) State regulation

The business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.

(b) Federal regulation

No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: Provided, That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act,

and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended (15 U.S.C. 41 et seq.), shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

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15 USC Sec. *1013*. Suspension until June 30, 1948, of application of certain Federal laws; Sherman Act applicable to agreements to, or acts of, boycott, coercion, or intimidation

(a) Until June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act (15 U.S.C. 41 et seq.)., and the Act of June 19, 1936, known as the Robinson-Patman Anti-Discrimination Act, shall not apply to the business of insurance or to acts in the conduct thereof.

(b) Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion, or intimidation.

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15 USC Sec. *1014*

Sec. 1014. Effect on other laws

Nothing contained in this chapter shall be construed to affect in any manner the application to the business of

insurance of the Act of July 5, 1935, as amended, known as the National Labor Relations Act (29 U.S.C. 151 et seq.), or the Act of June 25, 1938, as amended, known as the Fair Labor Standards Act of 1938 (29 U.S.C. 201 et seq.), or the Act of June 5, 1920, known as the Merchant Marine Act, 1920 (46 App. U.S.C. 861 et seq.).

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15 USC Sec. *1015*

Sec. 1015. "State" defined

As used in this chapter, the term "State" includes the several States, Alaska, Hawaii, Puerto Rico, Guam, and the District of Columbia.

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42 USC Sec. *300e*

SUBCHAPTER XI – HEALTH MAINTENANCE ORGANIZATIONS

Sec. *300e*. Requirements of health maintenance organizations

(a) "Health maintenance organization" defined

For purposes of this subchapter, the term "health maintenance organization" means a public or private entity which is organized under the laws of any State and which (1) provides basic and supplemental health services to its members in the manner prescribed by subsection (b) of this section, and (2) is organized and operated in the manner prescribed by subsection (c) of this section.

(b) Manner of supplying basic and supplemental health services to members

A health maintenance organization shall provide, without limitations as to time or cost other than those prescribed by or under this subchapter, basic and supplemental health services to its members in the following manner:

> (1) Each member is to be provided basic health services for a basic health services payment which (A) is to be paid on a periodic basis without regard to the dates health services (within the basic health services) are provided; (B) is fixed without regard to the frequency, extent, or kind of health service (within the basic health services) actually furnished; (C)

except in the case of basic health services provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, is fixed under a community rating system; and (D) may be supplemented by additional nominal payments which may be required for the provision of specific services (within the basic health services), except that such payments may not be required where or in such a manner that they serve (as determined under regulations of the Secretary) as a barrier to the delivery of health services. Such additional nominal payments shall be fixed in accordance with the regulations of the Secretary. If a health maintenance organization offers to its members the opportunity to obtain basic health services through a physician not described in subsection (b)(3)(A) of this section, the organization may require, in addition to payments described in clause (D) of this paragraph, a reasonable deductible to be paid by a member when obtaining a basic health service from such a physician. A health maintenance organization may include a health service, defined as a supplemental health service by section *300e* -1 of this title, in the basic health services provided its members for a basic health services payment described in the first sentence. In the case of an entity which before it became a qualified health maintenance organization (within the meaning of section *300e* -9(d) (FOOTNOTE 1) of this title) provided comprehensive health services on a prepaid basis, the requirement of clause (C) shall not apply to such entity until the expiration of the forty-eight month period beginning with the month following the month in which the entity became such a

qualified health organization. The requirements of this paragraph respecting the basic health services payment shall not apply to the provision of basic health services to a member for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or an insurance policy but only to the extent such benefits apply to such services. For the provision of such services for an illness or injury for which a member is entitled to benefits under such a law, the health maintenance organization may, if authorized by such law, charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law, the insurance carrier, employer, or other entity which under such law is to pay for the provision of such services or, to the extent that such member has been paid under such law for such services, such member. For the provision of such services for an illness or injury for which a member is entitled to benefits under an insurance policy, a health maintenance organization may charge or authorize the provider of such services to charge the insurance carrier under such policy or, to the extent that such member has been paid under such policy for such services, such member.

(FOOTNOTE 1) See References in Text note below.

"(2) For such payment or payments (hereinafter in this subchapter referred to as "supplemental health services payments") as the health maintenance organization may require in addition to the basic health services payment, the organization may provide to each of its members any of the health services which are

included in supplemental health services (as defined in section *300e* -1(2) of this title). Supplemental health services payments which are fixed on a prepayment basis shall be fixed under a community rating system unless the supplemental health services payment is for a supplemental health service provided a member who is a full-time student (as defined by the Secretary) at an accredited institution of higher education, except that, in the case of an entity which before it became a qualified health maintenance organization (within the meaning of section *300e*-9(d) (FOOTNOTE 1) of this title) provided comprehensive health services on a prepaid basis, the requirement of this sentence shall not apply to such entity during the forty-eight month period beginning with the month following the month in which the entity became such a qualified health maintenance organization.

(3)(A) Except as provided in subparagraph (B), at least 90 percent of the services of a physician which are provided as basic health services shall be provided through –

(i) members of the staff of the health maintenance organization,

(ii) a medical group (or groups),

(iii) an individual practice association (or associations),

(iv) physicians or other health professionals who have contracted with the health maintenance organization for the provision of such services, or

(v) any combination of such staff, medical group (or groups), individual practice association (or associations) or physicians or other health professionals under contract with the organization.

(B) Subparagraph (A) does not apply to the provision of the services of a physician –

(i) which the health maintenance organization determines, in conformity with regulations of the Secretary, are unusual or infrequently used, or

(ii) which are provided a member of the organization in a manner other than that prescribed by subparagraph (A) because of an emergency which made it medically necessary that the service be provided to the member before it could be provided in a manner prescribed by subparagraph (A).

(C) Contracts between a health maintenance organization and health professionals for the provision of basic and supplemental health services shall include such provisions as the Secretary may require, but only to the extent that such requirements are designed to insure the delivery of quality health care services and sound fiscal management.

(D) For purposes of this paragraph the term "health professional" means physicians, dentists, nurses, podiatrists, optometrists, and such other individuals engaged in the delivery of health services as the Secretary may by regulation designate.

(4) Basic health services (and only such supplemental health services as members have contracted for) shall within the area served by

the health maintenance organization be available and accessible to each of its members with reasonable promptness and in a manner which assures continuity, and when medically necessary be available and accessible twenty-four hours a day and seven days a week, except that a health maintenance organization which has a service area located wholly in a non-metropolitan area may make a basic health service available outside its service area if that basic health service is not a primary care or emergency health care service and if there is an insufficient number of providers of that basic health service within the service area who will provide such service to members of the health maintenance organization. A member of a health maintenance organization shall be reimbursed by the organization for his expenses in securing basic and supplemental health services other than through the organization if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(5) To the extent that a natural disaster, war, riot, civil insurrection, or any other similar event not within the control of a health maintenance organization (as determined under regulations of the Secretary) results in the facilities, personnel, or financial resources of a health maintenance organization not being available to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of paragraphs (1) through (4) of this subsection, such requirements only require the organization to make a good-faith effort to provide or arrange for the provision of

such service within such limitation on its facilities, personnel, or resources.

(6) A health maintenance organization that otherwise meets the requirements of this subchapter may offer a high-deductible health plan (as defined in section 220(a)(2) of title 26).

(c) Organizational requirements

Each health maintenance organization shall –

(1)(A) have –

(i) a fiscally sound operation, and

(ii) adequate provision against the risk of insolvency, which is satisfactory to the Secretary, and (B) have administrative and managerial arrangements satisfactory to the Secretary;

(2) assume full financial risk on a prospective basis for the provision of basic health services, except that a health maintenance organization may (A) obtain insurance or make other arrangements for the cost of providing to any member basic health services the aggregate value of which exceeds $5,000 in any year, (B) obtain insurance or make other arrangements for the cost of basic health services provided to its members other than through the organization because medical necessity required their provision before they could be secured through the organization, (C) obtain insurance or make other arrangements for not more than 90 per centum of the amount by which its costs for any of its fiscal years exceed 115 per centum of its income for such fiscal year, and (D) make arrangements with physicians or other health

professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions;

(3)(A) enroll persons who are broadly representative of the various age, social, and income groups within the area it serves, except that in the case of a health maintenance organization which has a medically underserved population located (in whole or in part) in the area it serves, not more than 75 per centum of the members of that organization may be enrolled from the medically underserved population unless the area in which such population resides is also a rural area (as designated by the Secretary), and (B) carry out enrollment of members who are entitled to medical assistance under a State plan approved under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) in accordance with procedures approved under regulations promulgated by the Secretary;

(4) not expel or refuse to re-enroll any member because of his health status or his requirements for health services;

(5) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery entities providing health services for the organization) and the members of the organization;

(6) have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance

program for its health services which program (A) stresses health outcomes, and (B) provides review by physicians and other health professionals of the process followed in the provision of health services;

(7) adopt at least one of the following arrangements to protect its members from incurring liability for payment of any fees which are the legal obligation of such organization –

(A) a contractual arrangement with any hospital that is regularly used by the members of such organization prohibiting such hospital from holding any such member liable for payment of any fees which are the legal obligation of such organization;

(B) insolvency insurance, acceptable to the Secretary;

(C) adequate financial reserve, acceptable to the Secretary; and

(D) other arrangements, acceptable to the Secretary, to protect members,

except that the requirements of this paragraph shall not apply to a health maintenance organization if applicable State law provides the members of such organization with protection from liability for payment of any fees which are the legal obligation of such organization; and

(8) provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), and effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information

(which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (A) the cost of its operations, (B) the patterns of utilization of its services, (C) the availability, accessibility, and acceptability of its services, (D) to the extent practical, developments in the health status of its members, and (E) such other matters as the Secretary may require.

The Secretary shall issue regulations stating the circumstances under which the Secretary, in administering paragraph (1)(A), will consider the resources of an organization which owns or controls a health maintenance organization. Such regulations shall require as a condition to consideration of resources that an organization which owns or controls a health maintenance organization shall provide satisfactory assurances that it will assume the financial obligations of the health maintenance organization.

(d) Application of rules by certain health maintenance organizations

An organization that offers health benefits coverage shall not be considered as failing to meet the requirements of this section notwithstanding that it provides, with respect to coverage offered in connection with a group health plan in the small or large group market (as defined in section 300gg-91(e) of this title), an affiliation period consistent with the provisions of section 300gg(g) of this title

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29 U.S.C. §2510.3-1 Employee welfare benefit plan.

[Logo] ERISA 3(1)

Preamble

(a) *General.*

(1) The purpose of this section is to clarify the definition of the terms "employee welfare benefit plan" and "welfare plan" for purposes of title I of the Act and this chapter by identifying certain practices which do not constitute employee welfare benefit plans for those purposes. In addition, the practices listed in this section do not constitute employee pension benefit plans within the meaning of section 3(2) of the Act, and, therefore, do not constitute employee benefit plans within the meaning of section 3(3). Since under section 4(a) of the Act, only employee benefit plans within the meaning of section 3(3) are subject to title I of the Act, the practices listed in this section are not subject to title I.

(2) The terms "employee welfare benefit plan" and "welfare plan" are defined in section 3(1) of the Act to include plans providing"

(i) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or

(ii) any benefit described in section 302(c) of the Labor Management Relations Act, 1947 (other than pensions on retirement or

death, and insurance to provide such pensions)." Under this definition, only plans which provide benefits described in section 3(1)(A) of the Act or in section 302(c) of the Labor-Management Relations Act, 1947 (hereinafter "the LMRA") (other than pensions or retirement or death) constitute welfare plans. For example, a system of payroll deductions by an employer for deposit in savings accounts owned by its employees is not an employee welfare benefit plan within the meaning of section 3(1) of the Act because it does not provide benefits described in section 3(1)(A) of the Act or section 302(c) of the LMRA. (In addition, if each employee has the right to withdraw the balance in his or her account at any time, such a payroll savings plan does not meet the requirements for a pension plan set forth in section 3(2) of the Act and, therefore, is not an employee benefit plan within the meaning of section 3(3) of the Act).

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(j) *Certain group or group-type insurance programs.* For purposes of title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which

(1) No contributions are made by an employer or employee organization;

(2) Participation [sic] the program is completely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit themto the insurer; and

(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

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